# Exhibit 42

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
NO. 01CV12257-PBS

In re: PHARMACEUTICAL )
INDUSTRY AVERAGE WHOLESALE )
PRICE LITIGATION )
)
THIS DOCUMENT RELATES TO: )
ALL ACTIONS )


DEPOSITION OF ROBERT C. FARIAS, called as a witness by and on behalf of the Defendants, pursuant to the applicable provisions of the Federal Rules of Civil Procedure, before P. Jodi Ohnemus, Notary Public, Certified Shorthand Reporter, Certified Realtime Reporter, and Registered Merit Reporter, within and for the Commonwealth of Massachusetts, at the offices of Harvard Pilgrim Health Care, 93 Worcester Road, Wellesley, Massachusetts, on Wednesday, 20 October, 2004, commencing at 10:05 a.m.

APPEARANCES:

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EXHIBITS





ROBERT C. FARIAS,
having first been duly sworn,
testified as follows to
direct interrogatories

BY MR. MANGI:

Q. Good morning, Mr. Farias. As I introduced myself earlier, I'm Adeel Mangi from Patterson, Belknap, Webb & Tyler, and we represent the Defendants in this action here today. Have you ever been deposed before?

A. I have not, no.

Q. Okay. Let me give you some of the ground rules for a deposition.

A. Sure.

Q. First of all, it's important to answer any questions verbally so that the court reporter can take them down.

A. Uh-huh. Yes.

Q. If at any point a question that I ask is unclear, please feel free to tell me that, and I'll do my best to rephrase it.

A. Okay.

Q. If at any point you need a break, feel free to let me know. We'll do that. Okay?
A. Yes.
Q. Okay.
MR. NALVEN: If I may, just one other thing, Mr. Farias. From time to time I may interpose an objection to the question --
THE WITNESS: Sure.
MR. NALVEN: -- for various reasons that you may not understand.
THE WITNESS: Uh-huh.
MR. NALVEN: Your lawyer can instruct you what to do. I only ask that you give me at least a half second between the time that the question is asked and the time the question is answered for me to say "objection --"
THE WITNESS: Will do.
MR. NALVEN: If it's called for. Thanks very much.
Q. Now, you understand that you're here today as a corporate representative speaking on behalf of Harvard Pilgrim, correct?



A. Yes.
Q. What did you do to prepare for your deposition today?
A. I spoke with Harvey.
Q. Anything else?
A. No. That was it. I did review the participating hospital agreement to look at what language was specifically represented in there related to drug pricing.
Q. Did you look at any other documents?
A. No. I looked at the hospital agreement.
Q. Did you speak with anyone other than Mr. Cotton in preparation for your deposition today?
A. I spoke with Richard Francis. He had -- actually, it wasn't directly in preparation for this, but he had spoken to me previously. He's in the reimbursement team and reports to me.
Q. What did you discuss with Mr. Francis?
A. He had told me what his involvement was.
Q. Do you have an understanding as to what this case is about?
MR. NALVEN: Objection.



Q. You can answer.
A. Okay. Not in depth. I mean, Harvey briefed me, but I don't have an in-depth understanding.
Q. Other than discussions with Mr. Cotton, do you have any other knowledge about what this -- about this case?
A. No, I do not.
Q. Okay. Can you, just by way of background, describe for me your educational background.
A. Sure.
Q. After high school.
A. Yeah. I have an undergraduate degree -- bachelor of science -- in health services administration, and I have an MBA.
Q. When did you get the bachelor's degree?
A. 1982.
Q. What institution did you attend?
A. Providence College.
Q. And then when did you get the master's qualification?
A. In 1989.



Q. From what institution did you get that?
A. Providence College.
Q. After graduating with your bachelor's degree in 1982, did you take up employment?
A. Yes.
Q. Where did you start working then?
A. Memorial Hospital of Rhode Island.
Q. What was your title at Memorial Hospital?
A. I had several titles there. Initially, I was an employment coordinator -- I guess the title was, then a compensation administrator, and then a staff accountant.
Q. I take it none of those positions involved issues relating to drug pricing or reimbursement.
A. Well, not directly pricing, no.
Q. Was there some indirect connection to these issues?
A. The only -- I mean, as a stretch, reimbursement -- part of my job is in the finance department as a staff accountant -- was preparing Medicare cost reports, which, you know, is hospital reimbursement, but not reimbursement in the sense

of paying providers.
Q. Those cost reports assess the amounts that the hospital was being paid in relation to services rendered to Medicare patients, is that correct?
A. It's a standard form requirement, HCFA 2552 Medicare cost reports. All hospitals that are participating in Medicare have to file these reports.
Q. How long did you remain employed at Memorial Hospital?
A. Eight and a half years.
Q. So, that was from 1982 until about 1990?
A. Uh-huh.
Q. The three positions you described earlier, did those cover the entire period of your employment for Memorial?
A. Yes. Uh-huh.
Q. Also, just for the court reporter's benefit, if you will let me finish the question before answering, just so she can get it in the transcript.
A. Yes.



Q. As part of your responsibilities as a staff accountant, did you gain an understanding of the methodology that Medicare used to reimburse Memorial?
MR. NALVEN: Objection.
Q. You can answer.
A. Yes.
Q. Okay. And what was your understanding of the methodology that Medicare was using to reimburse Memorial?
MR. NALVEN: Objection.
Q. Go ahead.
A. Okay. For -- it was -- those were the early days of the prospective payment system for inpatient services. We were reimbursed, you know, according to DRG -- a predetermined payment methodology. The cost report was used as a mechanism for settling for those areas that were not reimbursed according to the prospective reimbursement system.
So, at that time on the outpatient side, it was -- you know, it was an aggregate form of



reimbursement. It wasn't on a claims level of reimbursement. So, it would be a cost or some formula related to cost reimbursement. In addition to that, there was medical education costs that, you know, that Medicare would pay the hospitals.
Q. Incidentally, as we proceed, when counsel puts forward an objection, he's just securing it for the record for the transcript. So, you should still go ahead and answer the questions after he's made his objection.
A. I understand.
Q. Unless, of course, your attorney directs you not to answer a question. Okay. In 1990 you left your position at Memorial, is that correct?
A. Yes.
Q. Did you then enter your MBA program?
A. No. I -- my MBA program was done part time.
Q. Okay. What job did you move to in '99?
A. I went to Miriam Hospital in Providence.
Q. I'm sorry. Is that Miriam?
A. Miriam, yes.



Q. M-y-r-i-a-m?
A. M-i-r-i-a-m.
Q. How long did you remain at Miriam Hospital?
A. Four and a half years.
Q. Until sometime in 1994?
A. Uh-huh.
Q. And what position did you hold at Miriam Hospital?
A. The title was reimbursement supervisor.
Q. You held that title throughout your time at Miriam?
A. Yes.
Q. What were your responsibilities as a reimbursement supervisor?
A. I had responsibility for -- again, the third-party reimbursement, Medicare cost reports, also a lot of my time was spent -- there was a teaching program there managing and understanding the -- it was a significant part of reimbursement, the scheduling of the interns and residents -- not doing that, but understanding it and incorporating

that appropriately into the Medicare cost reports. I also had responsibility with -- along with the billing department -- for managing the hospital's charge, uhm, description master. Working with the third-party payers, Blue Cross, uhm, so forth.

Q. Okay. During your time at Miriam Hospital, did you have any knowledge regarding what Miriam paid to acquire drugs?

A. No, I did not.

Q. Okay. Do you know whether or not the price paid to acquire drugs was tied to any particular benchmarks?

MR. NALVEN: Objection.

A. I do not know that.

Q. How about at your time at Memorial Hospital, do you have any knowledge as to what Memorial paid to acquire drugs?

A. No.

Q. Do you know whether or not that price was tied to any benchmarks?

MR. NALVEN: Objection.

A. No.



Q. Okay. So, in 1994 you left Miriam Hospital, is that correct?

A. Uh-huh.

Q. Where did you move to in '94?

A. Charlton Memorial Hospital in Fall River, Mass.

Q. You had also acquired your MBA by this time?

A. Yes.

Q. How long did you remain at Charlton Hospital?

A. 18 months.

Q. Until sometime in '95?

A. Actually, I think you've got the years a little bit wrong.

Q. Do I?

A. Yeah, I think. It was -- I was -- I'm trying to remember now. Miriam through '95, because I came here in 1996 -- December of '96. So, you do the math.

Q. So, you were at Charlton from sometime around '95 to sometime around '96?



A. Yes, right.

Q. Okay. What was your title at Charlton Memorial Hospital?

A. Same as I had at Miriam.

Q. Reimbursement --

A. Supervisor, yes.

Q. -- supervisor. You held that title throughout your time at Charlton Memorial?

A. Yes.

Q. What were your responsibilities?

A. The same responsibilities. Very similar responsibilities.

Q. While at Charlton, did you gain an understanding as to what Charlton was paying to acquire drugs?

A. No.

Q. And in 1996, you came to Harvard, is that correct?

A. That's right, yes.

Q. Which entity did you join in 1996?

A. I'm sorry. I don't understand.

Q. Sure. Well, who was your employer in



1996?

A. Harvard Pilgrim Health Care.

Q. Okay. Have you worked at Harvard Pilgrim continuously from 1996 to the present?

A. Yes.

Q. Okay. Would you take me through your job titles during that time period.

A. Sure. When I came to Harvard Pilgrim my first title was senior regional business consultant. I was in that role for 18 months. That position involved -- I had a portfolio of providers that I was responsible for. As that time it was -- it was a couple of things. It was contracting with those providers. In addition, there was a responsibility where we would work with them on their performance, specifically in the concept of the physician groups, the local care units. We would go out and do performance management meetings to talk with them about how they were performing within the various financial models that they were contracted under.

Q. Okay. What was the next title you moved

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to?
A. Next title was senior project manager; and I did that for about two years. That function was in the network management area -- a variety of projects related to network management that could be related to medical management, could be related to referral authorization type things; could be related to managing recontracting efforts. Just a wide variety of projects.
Q. When you say, "network," you're referring to networks of providers?
A. That's right. It was an internally-focused position.
Q. What do you mean by that?
A. Meaning that I didn't have contact with providers. I worked on projects that supported the work of network management.
Q. Okay. You held that position for about two years you said?
A. That's right.
Q. Okay. What was the next area that you moved into?

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A. Next area was specifically to the contracting department in a project management role. That title was manager of planning and administration.
Q. Okay. And you moved into that position sometime around 2000, is that correct?
A. Probably about 2000, yeah.
Q. What were your responsibilities in that position?
A. In that position I was responsible for both the administrative side of managing the contracting department and the administrative side -- I mean the departmental administrative budget, the infrastructure of the department -- project management specific to the contracting department. For example, you know, when recontracting was, you know, kicking off, I would be responsible for drafting, you know, notification letters that would go out to the -- to the providers, responsible for working with legal on updating the contract templates, and also, managing the work flows related to recontracting. And again, a wide

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variety of projects. You know, liaisons with other departments and so forth.
Q. The focus you said was entirely on the administrative side of managing the department?
A. Administration and planning. The planning -- it was really a split function, and it continues to be. But the planning side was related to, you know, the significant, you know, project business unit initiatives, contracting being primarily --
Q. How long did you remain in that position?
A. Actually, it was a little bit of an evolution. Probably about a year. That position evolved into my current role, director of planning and administration. When there was a reorganization, contracting became more of a broad business unit again. Network service and operations is the name of the business unit. So, my title now and following being manager of planning and administration for contracting was director of planning administration for network service and operations.
MR. MANGI: I'm sorry. Could you read

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back that last answer, please.
(Answer read back.)
Q. So, your current position is director of planning and administration, right?
A. Right.
Q. And you've held that since 2001.
A. Yeah.
Q. Okay. Have your responsibilities changed from your manager of planning and administration position?
A. Yes. In addition to those responsibilities, I have reporting -- folks reporting to me, including the provider communications and training area. There's a small group of project managers and a budget coordinator which, again, they focus primarily on the infrastructure and administration side of things. In addition to that, the provider reimbursement area reports to me.
Q. What are your responsibilities in relation to that provider reimbursement area?
A. The manager of provider reimbursement

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reports to me.
Q. And who is that manager?
A. Steve Twelves.
Q. Now, the manager of planning and administration position you referred to earlier --
A. Uh-huh.
Q. -- was that also focused on provider contracting?
A. Uh-huh.
Q. Okay. In your current position do you have any responsibility for pharmacies or pharmacy contracting?
A. No.
Q. Okay. Do you have any dealings with pharmacy benefits managers or PBMs?
A. No.
Q. Okay. So, is it fair to say that throughout your time at Harvard Pilgrim, your focus has been on the provider or medical side, as opposed to the pharmacy side of the business?
MR. NALVEN: Objection.
A. Yes.

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Q. Okay. Now, in your current position, do you subscribe to any industry pricing publications?
MR. NALVEN: Objection.
A. I don't. I don't --
Q. Others in your department do?
A. The reimbursement -- I don't know the details around what the reimbursement department -- if they subscribe to the document, you know, anything -- or if they get the information online. I don't know.
Q. Okay.
MR. NALVEN: Note my objection to the prior question, please.
Q. Okay. What price reporting publications does Harvard Pilgrim use?
A. As stated in our contracts, the Medicare AWP, average wholesale price.
Q. Let me back up a bit.
A. Sure.
Q. Do you understand that -- whether AWP is published anywhere?
A. I understand it's provided by Medicare.

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Q. So, your understanding is that AWP is provided to Harvard Pilgrim by Medicare?
A. Uh-huh.
Q. Where do you come by that understanding?
A. The way we describe it in our provider contracts is, "based on Medicare AWP updates."
Q. Is that contractual language the only basis for your view that AWP is provided to Harvard Pilgrim by Medicare?
A. That and what I've known from my reimbursement staff, yes.
Q. Are you familiar with First Data Bank?
A. No.
Q. Have you ever heard of First Data Bank?
A. No.
Q. Have you ever heard of Redbook?
A. Redbook I've heard of, yes.
Q. Okay. Do you know what Redbook is? And we're not talking about the ladies' magazine.
A. No. I know. I don't know specifically.
Q. Okay. Do you have a general understanding as to the nature of that publication?

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MR. NALVEN: Objection.
A. No.
Q. Are you a member of any professional associations or industry associations?
A. No.
Q. Are you familiar with Harvard Community Health Plans?
A. Yes.
Q. Okay. What is the relationship between Harvard Community Health Plan and Harvard Pilgrim Health Care?
A. Well, Harvard Community Health Plan was one of the organizations that merged with Pilgrim Health Care to form Harvard Pilgrim Health Care.
Q. Okay. And that merger took place around 2000, is that correct?
A. It was prior to that. It was prior to my coming to Harvard Pilgrim.
Q. Okay. So, when you came to Harvard Pilgrim that merger had already taken place.
A. Yes.
Q. Okay. Does Harvard Pilgrim at present own

any pharmacies?
A. Not to my knowledge.
Q. Does it own any provider networks?
A. I guess I don't understand what you mean by "own."
Q. Well, does it own any hospitals?
A. No.
Q. Okay. Does it have any physicians' groups -- practicing physicians that are direct employees of Harvard Pilgrim?
A. I don't -- there is Nashua Medical Group in New Hampshire, which I don't understand fully the reporting relationship, but I believe they're an owned small group.
Q. Did you say it was natural medical?
A. Nashua.
Q. How would you spell that?
A. N-a-s-h-u-a.
Q. Okay. Do you know what -- is that a -- is that a group of practicing physicians?
A. Yes, it's a small group.
Q. Okay.



A. Yeah.
Q. And it's your understanding that Harvard Pilgrim owns that practice?
A. Yes.
Q. Do you have any involvement in relation to that practice?
A. No.
Q. Okay. Do you have any knowledge regarding how that practice acquires drugs?
A. No.
Q. Do you have any knowledge regarding how that practice is reimbursed for drugs, if at all?
A. No.
Q. Do you know whether Harvard Pilgrim, at present, purchases drugs directly from any wholesalers or manufacturers?
A. I don't know.
Q. Do you know whether Harvard Pilgrim has ever purchased drugs directly from wholesalers or manufacturers?
A. I don't know.
Q. Now, your focus is on the provider side of



business, right?
A. That's correct.
Q. Do you have an understanding as to the methodology that Harvard Pilgrim uses at present to reimburse providers for drugs that are administered in office?
A. Yes.
MR. NALVEN: Objection.
Q. And to clarify the question, by "providers" here, I'm referring to physicians rather than hospitals.
A. Yes.
Q. Okay. What is the methodology that Harvard Pilgrim uses at present to reimburse physicians for drugs that are distributed in office?
MR. NALVEN: Objection.
A. We have a drug fee schedule.
Q. Does Harvard Pilgrim independently generate that drug fee schedule?
MR. NALVEN: Objection.
A. Independently? I --



Q. Yeah, I mean, is the fee schedule something that Harvard Pilgrim generates internally, or do you rely upon a vendor or some other entity to provide a fee schedule to you?
MR. NALVEN: Objection.
A. No. We generate the fee schedule based on information.
Q. When you say, "information," what are you referring to?
A. The AWP.
Q. What is the relation of the number on the fee schedules for any particular drug to its AWP?
A. It's a percentage of AWP.
Q. Okay. What is that percentage?
A. 95 percent.
Q. So, is it fair to say that Harvard Pilgrim currently reimburses providers for drugs administered in office at 95 percent of AWP?
A. Yes.
Q. Now, this drug fee schedule you referred to, is there only one master fee schedule that's applied to all practices?

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A. Yes.
Q. And that applies across all of Harvard Pilgrim's plans as well?
A. Yes.
Q. Who at Harvard Pilgrim is responsible for maintaining that fee schedule?
A. It --
MR. NALVEN: Objection.
A. The folks in our reimbursement department, Richard Francis.
Q. And they report in to you, is that correct?
A. Through the manager, yes.
Q. How often is the drug fee schedule updated?
A. It's -- it can vary. It's updated in accordance with the updates that we receive from Medicare. Generally, quarterly.
Q. How long has Harvard Pilgrim reimbursed physicians for drug administered in office at 95 percent of AWP?
A. I don't know.

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Q. Was that the methodology in use when you came to the company?
A. I don't know.
Q. Okay. How long do you know that the methodology -- this methodology has been in use?
A. At least the last three years.
Q. So, you know this methodology has been in use since 2001, is that correct?
A. Yes.
Q. And prior to 2001, you don't know what methodology Harvard Pilgrim used to reimburse providers for drugs administered in office?
A. That's correct.
Q. How did you come to know in 2001 that this methodology was in use?
MR. NALVEN: Objection.
A. Just through my involvement in the projects and the position I was in.
Q. Is it your understanding that that methodology was already in use prior to 2001, or was it being implemented when you first became a --
A. I don't know.

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Q. Now, let's switch gears for a moment and talk about hospitals.
A. Sure.
Q. Do you have an understanding as to the methodology that Harvard Pilgrim currently uses to reimburse hospitals for drugs that are administered to patients?
MR. NALVEN: Objection.
A. Yes.
Q. All right. What is that methodology?
MR. NALVEN: Objection.
A. The Harvard Pilgrim drug fee schedule.
Q. All right. Is that the same fee schedule that we discussed --
A. Yes.
Q. -- that's used in reimbursing providers?
A. Yes.
MR. NALVEN: Objection.
Q. Does that apply to both the inpatient and outpatient departments of hospitals?
A. Not necessarily. Actually, no.
Q. Okay.

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A. The nature of inpatient reimbursement is that we wouldn't pay according to a drug fee schedule.
Q. Can you describe what the reimbursement is that's used in relation to inpatient?
A. Inpatient, there could be a variety of reimbursement mechanisms. It could be a per diem. It could be a DRG reimbursement. And for some cases, it could be a case rate. In any of those methodologies, the reimbursement would be for all services received while inpatient, and there wouldn't be distinct payment for any ancillary outpatient or drug services.
Q. So, in relation to inpatients, Harvard Pilgrim does not pay any amount that's specific to reimbursement for drugs administered to the patients, is that correct?
MR. NALVEN: Objection.
A. That's correct. There is one instance where there could be payment for a drug: If a hospital were on a percent-of-charge contract, then, by the nature of the reimbursement

methodology, they would be paid a percentage of whatever charges the hospital submitted.
Q. And the charges would include a component that pertains to drug costs, is that correct?
A. It could, yes.
MR. NALVEN: Objection.
Q. In that instance, in the percent-of-charge case --
A. Uh-huh.
Q. -- do you have an understanding as to whether the amount that the hospital bills Harvard Pilgrim in relation to drugs can be expressed by reference to any particular benchmark?
MR. NALVEN: Objection.
A. That's a difficult question to answer. The hospitals establish their charges. I wouldn't know what they were basing that on.
Q. So, it's whatever the hospital would customarily charge for the drug is the amount that Harvard Pilgrim will pay in that instance, is that correct?
MR. NALVEN: Objection.



A. No, we would pay -- we would negotiate a discount off of charges.
Q. The discount that's negotiated in that instance, would that apply to all charges across the board, or would there be a specific negotiation in relation to drug reimbursement?
A. There would not be a specific related to drug reimbursement. There may be differences between inpatient and outpatient. Generally, that's what you would see.
Q. Well, sticking with the inpatient component --
A. Sure.
Q. -- I understand that the -- there may be a percentage discount of the charge that's negotiated. My question is, the amount that the hospital will charge in relation to drugs specifically --
A. Uh-huh.
Q. -- can that be expressed by reference to a particular benchmark, be it AWP or anything else?
MR. NALVEN: Objection.



A. I don't know.
Q. Do you know how common those percent of charge contracts are in relation to Harvard Pilgrim's overall hospital contracting?
A. They're rare.
Q. Okay.
MR. NALVEN: Note my objection.
Q. So that was the inpatient side. So, when you describe the use of Harvard Pilgrim's drug fee schedule --
A. Uh-huh.
Q. -- in relation to hospitals, were you referring them exclusively to the outpatient sector?
A. Yes.
Q. So, in relation to drugs that are administered to outpatients in hospitals --
A. Yes.
Q. -- is it fair to say that Harvard Pilgrim reimburses the hospitals at 95 percent of AWP?
A. Yes.
Q. How long has that methodology been in use?



MR. NALVEN: Objection.
A. Well, as I said, my awareness, the last three years.
Q. You became aware of that methodology in relation to its use --
A. Uh-huh.
Q. -- in outpatient departments in hospitals at the same time that you become aware of its use in relation to providers?
MR. NALVEN: Objection.
A. That's right.
Q. Do you know what methodology was in use in relation to reimbursing outpatients -- hospitals in relation to outpatients prior to 2001?
MR. NALVEN: Objection.
A. Unsure.
Q. When you say, "unsure," do you mean you have an idea but you're not certain about it?
A. I don't know.
Q. Okay. Now, in addition to paying providers -- when I say, "providers," now I'm referring to -- actually, let's -- let me withdraw

that question and let's be more clear. Switching back to physicians now --
A. Yes.
Q. -- when Harvard Pilgrim reimburses physicians in relation to drugs administered in office, does it break out a drug component versus an administration fee or a -- that's fine. Go ahead.
A. Yes.
Q. Okay. The drug component, that's what's expressed on the fee schedule, is that correct?
A. Both components would be expressed on a fee schedule.
Q. Okay. Now --
MR. NALVEN: Objection.
Q. -- the 95 percent of AWP --
A. Uh-huh.
Q. -- part of the fee schedule that you referred to earlier --
A. Uh-huh, right.
Q. -- that's the reimbursement in relation to the drugs, is that correct?



A. Correct.
Q. Okay. Does the fee schedule also contain a separate amount that's paid for administrative fees -- administration fees?
A. For some -- yeah. I mean, it's not that the fee schedule -- I mean, there are standard codes that provide for administration of drugs.
Q. Okay. And those are CPT codes, is that correct?
A. CPT or HCPCs, yeah.
Q. Okay. So, Harvard Pilgrim will reimburse a provider, both for a procedure of administering a drug in relation to the relevant CPT or HCPC code, and will reimburse at 95 percent of AWP in relation to the drug administered. Is that a fair statement?
A. It's fair, but I don't have complete knowledge of the instances where an administration code would be per -- you know what I mean -- if that happens in every case.
Q. Do you have an understanding of what providers -- and referring now to both physicians



and hospitals --
A. Yes.
Q. -- pay to acquire drugs?
A. No.
Q. Okay. Do you have an understanding as to whether the amount that they pay to acquire drugs can be expressed by reference to any particular benchmark?
MR. NALVEN: Objection.
A. I don't know.
Q. Okay. Have you ever heard of the term "whole acquisition cost" or WAC?
A. Yes.
Q. Okay. What's your understanding of that term?
A. Just as it describes itself, that it would be what -- the price that the providers pay to acquire the drug.
Q. Okay. So, is it fair to say that you understand that providers acquire drugs at or close to WAC?
A. I really don't know.



Q. Is it fair to say that your earlier answer when you described what you understood WAC to be --
A. Uh-huh.
Q. -- was based just on the language --
A. Yes.
Q. -- of the term?
A. Yes.
MR. NALVEN: Objection.
Q. You understand that providers acquire drugs at an amount lower than what Harvard Pilgrim reimburses them in relation to those drugs, is that correct?
A. I don't know that.
Q. Okay. Well, you understand that most of the providers that Harvard Pilgrim contracts with are in the business of making money rather than losing money, right?
MR. NALVEN: Objection.
A. I can't -- I don't know that.
Q. Okay. Well, do you generally assume that physicians Harvard Pilgrim is contracting with are acquiring drugs at a price lower than what you

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reimburse them for?
MR. NALVEN: Objection.
A. I don't know.
Q. Would others at Harvard Pilgrim be more familiar with that issue?
MR. NALVEN: Objection.
A. I couldn't answer for others.
Q. Okay. Is it fair to say that Harvard Pilgrim does not require providers to disclose their acquisition costs as part of their contracts with Harvard Pilgrim?
MR. NALVEN: Objection.
A. Within my area, we do not.
Q. Uh-huh. And indeed, Harvard Pilgrim doesn't require them to disclose their acquisition costs for drugs in any other way that you're aware of, is that correct?
A. Not that I'm aware of, no.
MR. NALVEN: Objection.
Q. Indeed, the providers' acquisition costs are not relevant to Harvard Pilgrim's calculation of the amount that it's going to reimburse them for

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drugs. Is that a fair statement?
MR. NALVEN: Objection.
A. Yes.
Q. So, indeed, if providers' acquisition costs for drugs were to change, that would not alter the amount that Harvard Pilgrim is reimbursing them for drugs, is that correct?
MR. NALVEN: Objection.
A. That's correct.
Q. And indeed, if Harvard Pilgrim were to learn more information about what providers paid to acquire drugs, that would not change the amount that Harvard Pilgrim is reimbursing for drugs. Is that a fair statement?
MR. NALVEN: Objection.
A. That's a fair statement.
Q. Now, what is your involvement at present in relation to Harvard Pilgrim's contracts with physicians?
MR. NALVEN: I'm sorry. May I hear the question again, please.
(Question read back.)

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MR. NALVEN: Objection.
A. I don't have direct involvement with physician contracting, other than providing the tools that the contracting consultants need as far -- you know, like the contract templates, the reimbursement strategy. That is what my --
Q. When you say, "contract consultants," what are you referring to there?
A. The staff that is responsible for directly working with the providers --
Q. And those are?
A. -- in negotiating and administering the contracts.
Q. Those are Harvard Pilgrim's employees, right?
A. That's correct.
Q. And when you refer to "reimbursement strategy," what are you talking about there?
A. The reimbursement staff reporting to me, you know, what -- how are we going to -- the physician fee schedule generally is a good example. The physician fee schedule is an RBRVS fee

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schedule -- how are we going to update the fee schedule in the coming year? That's what I'm talking about.
Q. Do you have an understanding as to the criteria Harvard Pilgrim uses when deciding whether or not to contract with a provider?
A. Yes.
Q. Okay. What are those criteria?
A. Well, generally, it's -- I mean, they have to be credentialed, and they have to meet all of the credentialing standards. There has to be a need. The fact of the matter is, in our service area, our network is robust. You know what I mean? So, we're not -- it's not like a network development situation where we're going out and seeking providers.
Q. Anything else?
A. No.
Q. Okay. Since Harvard Pilgrim has one fee schedule that it applies to all providers, is it fair to say that there is no negotiation between Harvard Pilgrim and providers over the amount that

will be reimbursed in relation to drugs administered in office?
MR. NALVEN: Objection.
A. It's difficult for me to say. I don't know.
Q. Okay, because you're not directly involved in that --
A. That's correct.
Q. -- administration process?
A. That's correct.
Q. Okay. Just let me finish the question so the court reporter can take that down, please. But you do know for a fact that there's one fee schedule that's applied across the board, and that there are no variations from that, is that correct?
A. That's correct.
Q. Has there ever been any discussion that you're aware of at Harvard Pilgrim about changing the methodology that's used to reimburse providers for drugs administered in office or in hospital outpatient departments?
MR. NALVEN: Objection.



A. Yes.
Q. Okay. When did that discussion take place?
A. Earlier this year.
MR. NALVEN: Objection.
MR. MANGI: What's your objection?
MR. NALVEN: It incorporated the previous question, which used terms that are ambiguous under the circumstances.
Q. So, "earlier this year," you're referring to what time period?
A. I would say the spring of 2004.
Q. Who was involved in that discussion?
A. It would have been a group of us within network management, the reimbursement manager, folks in contracting, reimbursement staff, myself.
Q. Who headed out that effort, do you know?
A. I mean, I would just say generally the reimbursement staff.
Q. Okay. What was discussed?
A. Really what the discussion grew out of was the fact that Medicare is changing its methodology



for reimbursing -- reimbursing drugs. And what we tried to understand -- because I understand there's a transition period that they're actually -- they changed their methodology in 2004, and that they're going to be continuing to change it over time. And the discussion stemmed from, okay, well, what are we, as a health plan, going to do? You know, what are our options, given that this change is occurring?
Q. And part of the reason for that was for the past few years Harvard Pilgrim has reimbursed providers for drugs administered in office at the same rate as Medicare, is that correct?
A. Not at the same rate, but based on the AWP updates.
Q. Okay.
A. Okay.
Q. How is the rate that Harvard Pilgrim reimburses providers for drugs administered in office different from what Medicare reimburses?
A. I don't know what the differential is between the two fee schedules.



Q. Okay. So, what was the result of that discussion pertaining to whether or not to change reimbursement methodologies?
A. Well, we -- for 2004, we continue to pay under the same methodology. So, we haven't executed a change yet.
Q. Uh-huh. Is a change contemplated?
A. Again, we're still having discussions, trying to understand what the market change is going to be.
Q. Okay.
MR. NALVEN: Note my objection.
Q. Are you familiar with the term "ASP"?
A. I've heard it, yes.
Q. Have you heard that term in relation to the Medicare changes we were just discussing?
A. Yes.
Q. Are you familiar with that term in any other context?
A. No.
Q. All right. Is it fair to say that there is still no settled definition of what ASP will be?

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MR. NALVEN: Objection.
A. I don't know.
Q. Okay. Do you have an understanding as to how ASP is calculated?
A. I do not.
Q. Now, we spoke earlier about the administrative fee component of reimbursement to providers for drugs administered in office. Do you recall that testimony?
A. Yes.
Q. Do you have an understanding as to whether that amount alone -- leaving aside drug reimbursement -- would be sufficient to cover providers' overhead costs?
MR. NALVEN: Objection.
A. I don't know.
Q. All right. And is that because you're not the person who works closely with providers?
MR. NALVEN: Objection.
A. It's because generally I wouldn't know what the overhead costs of a provider are.
Q. Do others at Harvard Pilgrim have that

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information?
A. I would say no.
Q. All right. To the best of your knowledge, has Harvard Pilgrim ever studied what providers' overhead costs are?
A. Not specifically, no.
Q. Why does Harvard Pilgrim use this 95 percent of AWP formula in relation to reimbursing providers for drugs administered in office?
A. I don't know the specific rationale.
Q. Do you have an understanding as to what the benefits are of using that formula?
MR. NALVEN: Objection.
A. In a general way, it provides consistency across our network -- consistent payment.
Q. Harvard Pilgrim could change that reimbursement methodology at any time it chose to do so, subject to contractual obligations. Is that a fair statement?
A. Subject to contractual obligations, yes.
MR. NALVEN: Objection.
Q. And indeed, if Harvard Pilgrim chose to

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move to a benchmark other than AWP, it could do that, correct?
MR. NALVEN: Objection.
A. Through a recontracting effort.
Q. Right, subject to contractual obligations. And indeed, it could have done so at any time in the past, subject to contractual obligations, correct?
MR. NALVEN: Objection.
A. Yes.
Q. If Harvard Pilgrim does decide to change the reimbursement methodology that it uses, would it be fair to say that the actual amounts that are paid to physicians are unlikely to change drastically?
MR. NALVEN: Objection.
A. I'm not sure --
Q. Sure. Well, let me clarify.
A. I understand.
Q. You discussed that there -- you said that there are discussions currently underway --
A. Uh-huh.

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Q. -- about whether or not Harvard Pilgrim should change the methodology?
A. Right.
Q. That it uses to reimburse, right?
A. Correct.
Q. And that current methodology is AWP minus 5 percent.
A. Correct.
Q. All right. My question is, if Harvard Pilgrim were to use a different methodology -- let's say it were to use wholesale acquisition cost plus a percentage, rather than AWP minus a percentage --
A. Sure, uh-huh.
Q. -- the actual dollar amounts that Harvard Pilgrim reimburses providers are unlikely to change. Is that a fair statement?
MR. NALVEN: Objection.
A. It's really unknown. It could be budget neutral. It could be less. It's unknown.
Q. Okay. Do you agree with me that if you take a higher number and a lower number, you can

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either minus a percentage from the higher number or add a percentage to the lower one, and you'll end up in the same place, right, as a general proposition?
A. Right.
Q. Okay. So, if Harvard Pilgrim were to move from an AWP minus formula to a WAC plus a percentage formula, it could, if it so chose, end up at the same number, is that correct?
MR. NALVEN: Objection.
A. Depends on what the differential is between WAC and AWP, and I don't know that.
Q. Okay. The discussions that you referred to about changing methodologies --
A. Uh-huh.
Q. -- were any -- was the use of any benchmarks other than AWP as a basis for reimbursement part of that discussion?
MR. NALVEN: Objection.
A. I mean, I know the concept of ASP was introduced, again, looking at the Medicare, but I don't know specifically, you know, we had gotten

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that far that we had decided or thought about using another benchmark.
Q. Okay. Was there a discussion about using ASP as a possible benchmark?
MR. NALVEN: Objection.
A. No, not specifically.
Q. Okay. Was there any discussion about using WAC as a benchmark?
A. Really, what --
MR. NALVEN: Objection.
A. Again, not specifically, and I'll just offer that really what it was is getting an understanding of what Medicare's approach was, and how we might or might not apply that approach.
Q. Now, in relation to the administrative fees for procedures, does Harvard Pilgrim pay the same amount for a procedure in a physician's office as it would for the same procedure if it were performed in a hospital setting?
A. I can't be sure if there's a differential -- if there would be a differential or not.
Q. Okay. Do you know as a general matter

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whether Harvard Pilgrim has a preference for drugs that are infused or injected to be administered in physician's offices versus in hospitals?
MR. NALVEN: Objection.
A. I don't know about a preference.
Q. Okay. Does Harvard Pilgrim regard one side of care as being more cost effective to Harvard Pilgrim as opposed to the other?
A. Again, it's -- I think it's a market -- a market issue, reimbursement. I mean, fee schedules have site of service differentials that I'm aware of, and that would be to the only extent that I would say that, but I don't --
Q. By "site of service," are you referring to geographical regions or are you referring to --
A. No, site of service as to the development of any fee schedule -- not any fee schedule, but provider fee schedules. Medicare employs a methodology called, "site of service differential" where they'll reimburse as a slight differential for services provided in a physician office versus in a hospital setting.

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Q. Do you have an understanding as to which is higher?
A. The physician side is higher.
Q. Okay. On what do you base that knowledge?
A. Based on my general knowledge of reimbursement.
Q. Okay. To the best of your knowledge, has Harvard Pilgrim ever studied or analyzed the relative costs of administration in physicians' offices versus in hospitals?
A. Could you define "cost."
Q. Sure. The cost to Harvard Pilgrim or the amount that Harvard Pilgrim pays to either a physician's office or a hospital. Has Harvard Pilgrim ever studied the relative costs of one versus the other?
A. I would imagine that -- I mean, I shouldn't say I imagine, but I imagine that they would have as part of a general analysis. I mean, we would do that with anything.
Q. Okay. Are you familiar with any specific studies?

A. No.
Q. Okay. Who would be responsible for conducting those studies?
A. It would -- it would be -- it would be really a coordination between our finance folks -- it could be several areas. It could be our finance folks. It could be trend folks. It could be folks on the network side of the reimbursement department.
Q. Do you know of any person in particular whose department that would fall within or who would have overall responsibility for such analysis?
A. General analysis -- and I don't know specifically, you know, the analysis that you're talking to, but general analysis -- again, I can go back to not the drug fee schedule, but the physician fee schedule, generally, there would be a project team, which would involve the reimbursement department, Steve Twelves, my reimbursement manager, along with a manager in an area called financial planning and analysis within our finance



area.
Q. Okay. Who is that manager?
A. His name is Chris McTiernan.
Q. Just to be clear, did you just distinguish between a drug fee schedule and a physician fee schedule?
A. I said the physician fee schedule update, generally. The physician fee schedule includes all the components. It would include E&M codes. It would include, you know, laboratory components. It would just include everything, all of the components of the --
Q. Okay. Part of which is the drug fee schedule?
A. That's correct.
Q. Does Harvard Pilgrim serve as a Medicare carrier?
A. I'm sorry. We have a First Seniority product, which is a Medicare product.
Q. Okay. Is that Medicare supplemental insurance?
A. It's supplemental.



Q. Let me withdraw that question. Why don't you tell me what that product is?
A. Okay. It's an HMO product for senior population. Instead of having Medicare, they participate in First Seniority.
Q. It's an alternative to Medicare?
A. Yes.
MR. COTTON: If you know, Bob.
Q. Are you aware that Medicare patients pay a percentage copayment in relation to drugs that are administered to them in physicians' offices?
A. I don't know the specifics of the Medicare program --
Q. Okay.
A. -- from the member side.
Q. Do you know whether Harvard Pilgrim offers any forms of insurance that cover any out-of-pocket expenses incurred by Medicare beneficiaries?
A. I don't know the details, no.
Q. When you say you "don't know the details," do you know whether or not such a product exists?
A. Well, I know our products generally



include -- you know, may include deductibles and copayments, but I wouldn't know the specifics.
Q. Okay. So, you don't know whether or not there are any products that cover the out-of-pocket expenses for a Medicare beneficiary?
A. No.
Q. Do you know whether or not drug manufacturers contract directly with providers?
A. I don't know.
Q. So, you have no idea whether drug manufacturers do or do not contract with physicians or hospitals. Is that a fair statement?
A. Yes.
Q. Do you know whether or not drug manufacturers have free sample programs? Have you ever heard of such programs?
A. I've heard of them. Yes.
MR. NALVEN: Objection.
Q. Okay. So you're aware that such free sample programs exist?
MR. NALVEN: Objection.
A. I don't know if they're programs. I know,

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you know, I know folks who work in the health profession that, you know, would have told me that, you know, we got samples, but --
Q. Are you familiar with the term "specialty pharmacy"?
A. Yes.
Q. Okay. And you know that Harvard Pilgrim contracts with specialty pharmacies, correct?
A. Yes.
Q. Okay. What is your involvement in relation to specialty pharmacies?
A. I don't have any direct relationship to it, no, none.
Q. Do you have an understanding as to how Harvard Pilgrim's arrangement with specialty pharmacies work?
MR. NALVEN: Note my objection.
A. In a general way.
Q. Okay. Who is the person at Harvard Pilgrim most knowledgeable about those specialty pharmacy arrangements?
A. I would assume it would be someone -- and

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I don't know who -- in the pharmacy area.
MR. NALVEN: You're aware that we've had a deposition of James Kenny.
MR. MANGI: I have already moved on.
MR. NALVEN: I'm sorry?
MR. MANGI: I am done with specialty pharmacies.
Q. Now, AWP or average wholesale price --
A. Uh-huh.
Q. -- you understand that that is a benchmark used for purposes of reimbursement, correct?
A. Yes.
Q. Okay, and basically --
MR. NALVEN: Objection.
Q. -- as we've discussed, you are aware that reimbursement is made at a percentage discount off AWP, right?
A. That's correct.
Q. Do you have any knowledge as to how AWP is determined?
A. No.
Q. So, as you reported earlier, all you know

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about it is that it's a number provided to Harvard Pilgrim by Medicare --
A. Through --
Q. -- that's your understanding?
A. Through Medicare, yes.
Q. Have you ever heard AWP referred to as "Ain't What's Paid," are you familiar with that?
A. No.
Q. Okay. Are you familiar with the major drug wholesalers operating in the market today?
MR. NALVEN: Objection.
A. No. I mean, I would know the names of some big pharmaceutical companies just from general knowledge, but no.
Q. Okay. Now, are you familiar with the term "prompt pay discount"?
A. Yes.
Q. Have you ever heard that term? What's your understanding of what a prompt pay discount is?
A. Again, just a standard, you know, business term. If you pay within a certain period of time

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that you would get -- be entitled to a discount. 10 percent if you pay within 30 days or something like that.
Q. All right. Okay. Are you aware that there are entities in the market, drug wholesalers, that are distinct from drug manufacturers?
A. Say that again.
Q. Yeah.
A. Please.
Q. Are you aware that there are drug wholesalers in the marketplace that are distinct from drug manufacturers?
A. No.
MR. MANGI: Can we take a short break.
(Recess was taken.)
Q. Has Harvard Pilgrim been involved in any litigations other than this one that pertain to drug pricing or reimbursement?
A. I don't know.
Q. Okay. Does Harvard Pilgrim -- withdraw that. Has Harvard Pilgrim ever taken the position that any providers have conspired with drug

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manufacturers to inflate drugs' average wholesale prices?
MR. NALVEN: Objection.
A. I don't know.
Q. Okay. So, to the best of your knowledge, Harvard Pilgrim has never taken that position.
A. That's correct.
MR. NALVEN: Objection.
Q. All right. To the best of your knowledge, has Harvard Pilgrim ever taken the position that any PBMs or pharmacies have conspired with drug manufacturers to inflate drugs' average wholesale prices?
MR. NALVEN: Objection.
A. To the best of my knowledge, they have not.
Q. To the best of your knowledge, has Harvard Pilgrim ever taken the position that drug manufacturers have artificially inflated the average wholesale prices for drugs?
MR. NALVEN: Objection.
A. I have no way of knowing.

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Q. Okay. So, to the best of your knowledge, Harvard Pilgrim has not taken that position?
A. That's correct.
MR. NALVEN: Objection.
Q. Let's turn to some documents.
MR. MANGI: Before we do that, Mr. Cotton, can we put a stipulation on the record to the effect that the documents produced by Harvard Pilgrim in this case -- which run from HPH 1 to HPH 1170 -- are authentic copies of documents produced from Harvard Pilgrim's files and are business records within the meaning of the federal rules of evidence?
MR. COTTON: Yes.
MR. MANGI: Let's start with this one right here. Off the record.
(Discussion off the record.)
MR. MANGI: Let' start with HPH 1 to 49. We will mark that as Exhibit 1, please.
(HPH 1-51 marked Exhibit Farias 001.)
Q. Actually, I apologize. It should go through to 51 rather than 49. I'm afraid a couple

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of pages eluded my staple. I realize it's a long document. I'll draw your attention to particular parts of it. But please familiarize yourself, and let me know when you're done.
MR. COTTON: Look it over so you know exactly what it is.
MR. NALVEN: With respect to the stipulation between defense counsel and counsel for HPHC, Plaintiffs reserve their rights to challenge authenticity and the evidentiary nature of the documents.
A. (Witness reviews document.) Uh-huh.
Q. Are you familiar with this document?
A. Yes.
Q. Okay. Have you seen this document before?
A. Yes.
Q. Okay. Is this a document that you use in the regular course of business?
A. I don't use it.
Q. Okay. Is this a document you had seen prior to preparing for your deposition today?
A. Yes.

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Q. Okay. Can you describe for me in general terms what this contract is -- who this contract is between?
A. Okay. Sure. This is -- Harvard Pilgrim contracts with physicians in a construct called "local care units." So, it would be groups of physicians. It could be an IPA, a PHO. It could be, you know, specific physician practices and so forth. There could be a -- this one in particular is with physicians and hospitals. So, there could be a hospital partner to the agreement as well. So, there are some variations. But, again, this is a local care unit.
It describes the responsibilities of, you know, just the regular definition, but it describes the responsibilities of the physicians and the plan under this arrangement.
Q. Uh-huh. When you refer to an IPA or PHO, what are you referring to? What do those stand for?
A. Independent practice association, physician/hospital association.

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Q. All right. Are those -- well, what are those?
A. Okay.
Q. What is an independent practice association?
A. Okay. It could be -- it's a group of physicians that come together as an entity for contracting purposes or other purposes.
Q. All right.
A. Physician/hospital association would be a hospital and a group of physicians that, again, come together for the purposes of contracting and other purposes.
Q. All right. Now, and on the page that's -- it has a Bates number, which is that number on the bottom right, the HPH number.
A. Yes.
Q. If you turn to Page HPH 4, there's -- in the fifth line down in brackets it says, "IPA. PHO or PO."
A. Uh-huh.
Q. What is the PO there?

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A. Physician organization.
Q. All right. How is a PO different from an IPA?
A. I'll be honest. I don't know how to describe that. I --
Q. Okay. Is it fair to say, though, that the PO is another instance of physicians coming together for purpose of --
A. Contracting, right.
Q. -- contracting?
A. Yes.
Q. Now, this particular document we're looking at, Exhibit 1, this is a template, is that right?
A. That's correct.
Q. When Harvard Pilgrim enters into contracts with either physicians -- or hospitals in this instance -- is this template the basis for negotiation as to contractual terms?
MR. NALVEN: Objection.
A. I'm not sure I understand "basis for negotiation."

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Q. Let me rephrase it. Is this form of contract offered to physicians or hospitals as a take-it-or-leave-it proposition, or is there a negotiation over specific terms?
A. There could be negotiation.
Q. Are there particular terms that are subject to negotiation, or is everything on the table?
A. Everything is not on the table.
Q. Okay. Is -- are the terms in relation to drug reimbursement subject to a negotiation?
A. Within -- the answer is no. I mean --
Q. Okay. Now, I'd like to draw your attention to HPH 6. Right at the top of the page there there's a definition of fee schedule, right?
A. Yes.
Q. Is that the same fee schedule that we've been referring to earlier today?
MR. NALVEN: Objection.
A. Yes.
Q. Uh-huh. And indeed, Harvard Pilgrim only has one fee schedule that it applies across the

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board, correct?
MR. NALVEN: Objection.
A. That's not true, that there's -- there's one drug fee schedule.
Q. You're quite right. Let me rephrase the question. There's only one drug fee schedule that Harvard Pilgrim has, which is always across the board.
A. Yes.
Q. Now, I'd like to draw your attention first to Page HPH 16. And under 4.0, "Compensation," you see that the document refers to Appendix B as containing the terms of compensation, right?
A. Yes.
Q. Okay. So, let's turn to Appendix B, which is at HPH 29. Okay. Under "Fee For Service Payments," do you see Paragraph A on "Physician Services"?
A. Yes.
Q. Okay. Could you review that paragraph, please, and let me know when you're done.
A. (Witness reviews document.) Yes.

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Q. Okay. Now, the second sentence of that states, "Fees payable shall be equal to the amount set forth in the plan's fee schedule --"
A. Yes.
Q. "-- in effect at the time." Now, am I correct in understanding then that there are different fee schedules for different plans?
A. Different? No.
Q. Okay. Well, what I'm trying to understand is -- my impression is that there's one drug fee schedule. So, when this contract refers to "amount set forth in the plan's fee schedule in effect at the time the services are rendered," is it referring to the possibility of there being more than one, or is it referring to the same fee schedule in there --
A. There are -- the drug fee schedule is a component of --
Q. Right.
A. -- the physician fee schedule.
Q. Okay. So, there are different fee schedules for different plans, but all of them

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incorporate the same drug fee schedule, is that correct?
A. I'm not sure when you're saying "different plans."
Q. Yeah. Well, I'm using the term in the contract here.
A. Oh, "Plan" is a defined term. That's Harvard Pilgrim Health Care.
Q. Okay.
A. So, that's one plan.
Q. I understand. Okay. When you say there are different physician fee schedules --
A. Uh-huh.
Q. -- what's the basis for that variation?
A. It's really a historical basis. Several years ago, and I don't know the exact time, we moved to a standard physician fee schedule called HPPO, which is our RPRVS-based fee schedule.
Q. When you say, "HPPO," what are you referring to?
A. It's the name, as it says here, "Insert name of applicable fee schedule." That's an

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internal name describing that fee schedule.
Q. What does that stands for?
A. Harvard Pilgrim Physician -- I don't know what the O stands for, but --
Q. Okay.
A. -- that's what it is. Prior to that -- and you may see references within the contract -- that there was a PIPA fee schedule, Pilgrim Independent Practice Association fee schedule. So, there may be providers that, you know, are still -- you know, contract has not been renegotiated, and they may still be under that fee schedule.
Q. Okay.
A. But these fee schedules, again, are made up of components. Okay.
Q. When was that prior fee schedule in use?
A. The PIPA fee schedule?
Q. Right,
A. Again, I don't recall the exact -- as I said, for some providers it may be in use now.
Q. All right.
A. Ah.

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Q. Let me rephrase the question then. When was it being inserted in contracts or used in contracts as a basis for reimbursement?
A. At least five years ago. I'm not certain of the time.
Q. Okay. And going back five years to 1999, at that point you don't know what the basis was for drug reimbursement, is that correct?
A. That's correct.
Q. Continuing on here in that same paragraph on Page HPH 29, the second paragraph -- I'm sorry -- second sentence, "Fee schedule shall be equal to the amount set forth in the plan's fee schedule in effect at the time services are rendered." And that continues, "Provided, however, that the inflator to the fee schedule shall not apply to certain codes included in the fee schedule." And it continues. What's the inflator that's being referred to there?
A. If there was a negotiated multiplier on certain codes within the fee schedule -- ranges of codes within the fee schedule.

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Q. Okay. So, the fee schedule in general is subject to negotiation, is that correct?
A. It can be.
Q. Okay. Would that negotiation include the drug fee schedule?
A. No.
Q. Okay. So, the drug fee schedule is nonnegotiable?
A. Right.
Q. Okay. The rest of the physician fee schedule can be subject to negotiation?
A. Could be, yes.
Q. Okay. Are you aware of instances where it has been changed through a process of negotiation?
A. Yes.
Q. Okay. What's the basis for those differentials?
MR. NALVEN: Objection.
A. The basis would be the same as it would be with any provider -- what the market would be dictating, what the provider's position is, leverage, book of business, just whatever would

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apply to any negotiation.
Q. So, it could be based on a competitive dynamic. Is that a fair statement?
MR. NALVEN: Objection.
A. I don't know that I would use that term, but market, yes.
Q. Okay. Some physicians or some practices would have more bargaining power than others. Is that a fair statement?
MR. NALVEN: Objection.
A. For many reasons, yes.
Q. Okay. What could some of those reasons be?
A. One example could be -- it could be, you know, the geographic area that they're located in. Again, these are -- these are general drivers. I have no knowledge of specific drivers.
Q. Uh-huh.
A. But just in the health care marketplace, geographic location, the size of the organization, whatever -- whatever -- however you define leverage.

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Q. And part of that is Harvard Pilgrim's aim is to ensure adequate coverage for its members, right?
A. Correct.
Q. So, if there is a particular specialty practice that's the only one in an area, they would have more leverage in negotiations. Is that a fair statement?
MR. NALVEN: Objection.
A. I wouldn't say they would. I would say they could.
Q. Now, the process of negotiation, does that encompass the amount that's paid to physicians as an administrative -- as an administration fee in relation to the administration of drugs?
A. Could you say the question again, please.
Q. Sure. Yeah. I mean, we spoke earlier about how Harvard Pilgrim reimburses 95 percent of AWP in relation to drugs that are administered, right?
A. Uh-huh. Right.
Q. And we also spoke about a separate

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administration fee that's paid in some instances where there is a CPT or a HCPCS code, correct?
A. Yes.
Q. This process of negotiation that leads to these inflators, does -- is that payment for administration fees --
A. Uh-huh.
Q. -- is that subject to negotiation?
A. I don't know if that's an excluded code. I don't know.
Q. Okay. Who would know whether or not that's part of -- that forms part of the process of negotiation?
A. I would -- more the reimbursement folks would know the specifics of what codes were allowable to inflate.
Q. Okay. And continuing on here, on HPH 29, it says, "Provided however, inflator to the fee schedule should not apply to certain provisions included in the fee schedule that are set at a particular rate and are not inflated for any provider across of plan's network."

The amount of drug reimbursement falls within that exception, is that correct?
A. That's correct.
Q. So, it's not subject to negotiation.
A. That's correct.
Q. I'd like to draw your attention now to HPH 31. You will see there Appendix C. You're referring to a quality advance program.
A. Correct.
Q. Okay. Are you familiar with that program?
A. Yes, I am.
Q. Okay. What is the quality advance program?
A. In general terms, it can be described as a pay-for-performance program that's offered to a group of our local care units. It includes several components. It includes a rewards for excellence program that is based on HEDIS measures. If they meet certain targets according to those HEDIS measures -- H-E-D-I-S -- measures that they would be subject to a payment, a per-member-per-month payment on that component.



In addition to the rewards for excellence component, there are specific clinical practice support components, focused areas that the LCUs, again, have targets to work towards. And if they are successful in achieving those targets, again, they are eligible for a per-member-per-month payout for those components. Under the clinical practice supports components, there are -- for adult LCUs, there are three measures. There is a radiology measure; there is a laboratory measure; and then there is a clinical IT component of that.
There are a couple of unique payouts for -- there are only three pediatric practices. ADHD, first line antibiotics measures that they have. In addition to that, there are other smaller components, but there is a medical director stipend that is awarded the medical director for administering the program -- again, having met certain criteria and demonstrating their support and their management of the program.
Q. You referred to HEDIS. What is HEDIS, if you know?



A. See, now you're going to ask me what -- it's -- I don't know what the acronym stands for, but what it is -- it's a national data set of quality measures based on claims submitted. That's what I know about that.
Q. Is cost control part of the assessment of quality pursuant to this program?
MR. NALVEN: Objection.
A. I don't understand.
Q. Yeah. If physicians are able to lower their costs --
A. Uh-huh.
Q. -- is that something that's assessed as part of this program?
MR. NALVEN: Objection.
A. Not specifically, no, no.
Q. Okay. Does this program include an assessment of drug utilization?
A. No.
Q. So, it doesn't, assess, for example, whether physicians are using some drugs versus others --



A. No.
Q. -- that may be different in terms of their cost to Harvard Pilgrim?
A. No. No.
MR. MANGI: Let's mark another document, please. This is HPH 52 to 75.
(HPH 52-75 marked Exhibit Farias 002.)
Q. Take a look at that, please, and let me know when you're done.
A. (Witness reviews document.) Okay.
Q. Okay. Are you familiar with this document?
A. I have a general knowledge of this document, not a deep familiarity.
Q. Okay. This, again, is a template, though, correct?
A. That's correct.
Q. This template pertains to physicians' groups, be they primary care or specialty, right?
A. Correct.
Q. Now, Harvard Pilgrim offers different products, is that right, different health insurance

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plans that the company offers?
A. Yes.
Q. Okay. Do some of those plans require members to go to primary care physicians and then get referrals to specialists?
A. Go to primary care physicians.
Q. Yeah. In other words, do some plans permit members to go directly to specialists and others require them to go through primary care physicians first?
A. The way you're asking the question, I don't know how to describe that. I mean, again, in general terms, a PPO would not require selection of a PCP.
Q. Right.
A. So, the answer would be no. HMO you require a PCP, and you would --
Q. So, it varies according to the type of plan?
A. Yes, right.
Q. And that instances where -- well, withdraw that question. Now, do these templates change from

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year to year, do you know?
MR. NALVEN: Objection.
A. To some extent, yes.
Q. Okay. Is there a master file of templates maintained somewhere to the best of your knowledge?
A. Master file? Yes. I mean, they're posted on a departmental bulletin board, yeah.
Q. Okay. And so, previous contracts from previous -- well, let me withdraw that. Templates from contracts of previous years are available on that bulletin board, is that correct?
A. Some are.
Q. Okay. If I wanted to ascertain the reimbursement methodologies that were used by Harvard Pilgrim prior to 2001, could I go to contracts for previous years to figure that out?
A. Possibly.
Q. Now, this is a template not a real contract.
A. That's correct.
Q. But a real contract would have the fee schedule attached to it, is that correct?

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A. I don't know that it would always have the fee schedule attached. It could be referenced.
Q. Okay. Are contracting providers given a copy of the fee schedule?
A. They're given a sample.
Q. Okay. Does the fee schedule expressly show the formula, 95 percent of AWP, or does it just contain dollar sums?
A. Dollar sums.
Q. Okay. So what would be contained in the drug component of the fee schedule? Would there be an NDC number and then a dollar amount?
A. I don't know what coding is used, but it would be a dollar amount.
Q. Okay. Is there anything on the fee schedule that indicates the methodology used to arrive at those numbers?
A. Not that I'm aware of.
Q. You have seen the fee schedules, is that correct?
A. I've seen the sample fee schedules, yes.
Q. Okay. Who at Harvard Pilgrim would know

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what reimbursement methodologies were in use prior to 2001 in relation to providers?
MR. NALVEN: Objection.
A. Richard Francis was here --
Q. Uh-huh.
A. -- then he may have some knowledge.
Q. Anyone else?
A. There could be some contracting managers that were here at the time that may have knowledge.
Q. Okay. Do you know of anyone in particular who may have that knowledge?
A. Again, besides Richard Francis, there's a contracting manager that was here then, Steve Kostos, K-o-s-t-o-s.
Q. What's Mr. Kostos position?
A. He's a contracting manager.
Q. Now, excuse me, on Exhibit 2, could I draw your attention to HPH 54, please. Do you see Paragraph 3.1 at the bottom of the page?
A. Yes.
Q. There's a reference there to the plans "claims payment, policies, and procedures as

detailed in the manual --"
A. Yes.
Q. Are you familiar with that manual?
A. Yes.
Q. Okay. In general terms, what does that manual contain?
A. Just as it describes, it contains our payment policies and procedures.
Q. Does that manual describe the methodologies that are used to arrive at the amounts of reimbursement in relation to drugs?
A. No.
Q. Okay. Does it contain any discussion of the amounts paid as administration fees in relation to drugs administered in office?
A. No. In fact, I don't -- probably offering -- I don't know that it -- I don't know that it even includes anything specific to drug payments.
Q. Okay. So, it just includes the logical nuts and bolts of how to submit a claim?
A. It includes that. It does include, you know, some specific -- for some specific lines of



business, you know, nuances, but I don't know if there is anything specific to drug reimbursement in there. I can't recall if there is.
Q. Let's turn to HPH 57, please. At the top of the page do you see 4.4A, states, "The plan reserves the right to conduct audits to verify the accuracy of members' bills in compliance with the plan's billing guidelines." This refers to the possibility of Harvard Pilgrim auditing providers, is that correct?
A. Yes.
Q. Okay. Has Harvard Pilgrim audited providers to the best of your knowledge?
A. Yes.
Q. Okay. Is that something that's done on an ongoing basis?
MR. NALVEN: Objection.
A. Yes.
Q. Okay. Are there particular triggering points for audits, or are audits conducted on a randomized basis?
A. I don't know the protocol.



Q. Okay. Do you know whether or not those audits include analysis of providers' acquisition costs for drugs?
A. I don't know.
Q. Okay. Who's in charge of those audits?
A. The audits are generally claims audits managed by a group within the claims services area.
Q. Is there a particular person that's in charge of that area?
A. The director is Terry Lee, and then I don't know the reporting structure under him, but Terry Lee is the in-charge guy.
MR. MANGI: Let's mark this as Exhibit 3, please.
(HPH 168-195 marked Exhibit Farias 003.)
Q. Actually, you know, before we get to that, perhaps I could just ask you one question generally, which is, the template we discussed earlier was a template for primary care physician/specialty care physicians. That's the one we were looking at earlier.
A. This one just now, yes.



MR. NALVEN: Is that 1 or 2?
MR. MANGI: 2.
Q. This was 2, yeah. We also looked at -- I have here some other documents that I haven't yet marked as exhibits, which are templates for primary care physicians and then specialty care physicians.
A. Uh-huh.
Q. Do you have any idea what the basis is for the distinction between, you know, templates for each of them or a template for both of them?
A. Yeah. No, I don't. These I'm not as familiar with as the medical service agreements.
Q. So, we were looking at Exhibit 3.
A. Yes.
Q. Now, this is a template of a contract with a hospital, correct?
A. Correct.
Q. Okay. And you will see on Page 168 that's referring to both inpatient and outpatient services --
A. Sure.
Q. -- that are being provided to members. I

draw your attention to Page 174, please. Paragraph 4.18 states that -- subject to exceptions -- "The payments to the hospitals will be made at the amount set forth in Exhibit A to this document," right?

A. Yes.

Q. And then below that it's one of those exceptions, which is -- well, let me withdraw that question. Below that in Clause B, there's a reference to -- and this is on Page HPH 174, "The parties agree to convert the methodology for payments for covered inpatient services rendered to members by hospital to a DRG-based methodology."

Do you know whether or not that conversion has taken place?

A. That conversion is taking place. It's underway.

Q. So, what is the previous -- preDRG methodology that's used for reimbursement with patients?

A. Predominantly per diem.

Q. Okay. So, the conversion here is from per



diem amounts to a DRG-based --

A. That's correct.

Q. And the clause continues that the conversion will not change the actual amounts that are being reimbursed --

A. That's correct.

Q. -- right? So, the idea there is, though the methodology is changing, the amounts that are being paid will remain the same.

A. That's correct.

Q. Okay. What's the basis for that clause?

MR. NALVEN: Objection.

A. The basis for the clause is that Harvard Pilgrim wants to standardize its reimbursement methodology -- inpatient reimbursement methodology to a DRG methodology. In order to execute that, because of -- there may be -- there could be several reasons. There could be reasons where that hospital -- that contract is expiring, we want to move them to the DRG methodology. Until the time happens or the analysis can be done so that we can agree upon what the budget neutral conversion is,



the contract may expire prior to that happening. So that we want to continue the contract, but we want to make sure that we don't wait until the next contracting cycle to move to the DRG methodology. So, it's to allow us the flexibility to move to the DRG methodology outside of -- possibly outside of the term of the contract.

Q. Okay. And this -- the last sentence of this clause, "Providing that the amounts that are being paid to the hospital are going to remain the same."

A. Uh-huh.

Q. That's necessary to ensure that hospitals will agree to be subject to this conversion, right?

MR. NALVEN: Objection.

A. That's correct.

Q. Because a hospital will say, fine, change your methodology, but the amounts that are reimbursed should not change, right?

A. That's correct.

Q. Okay. And indeed, the same position would likely be adopted by physicians if Harvard Pilgrim



were to change the methodology applied to them, right?

MR. NALVEN: Objection.

A. I'm sorry.

Q. Yeah. Well, here Harvard Pilgrim is changing the methodology it uses to reimburse hospitals, right?

A. Correct.

Q. But to ensure that hospitals will agree to that change taking place, it's giving them insurance that the change will be revenue neutral, right?

A. Correct.

Q. Okay. And that's necessary to ensure hospitals will agree to the change, right?

A. Correct.

MR. NALVEN: Objection.

Q. Now, if Harvard Pilgrim were to similarly change the methodology that it uses to reimburse physicians, it would likely have to give a similar assurance to ensure they'd enter into the contracts, right?

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MR. NALVEN: Objection.
A. I don't know that we can say that globally.
Q. Okay. What's your basis for thinking things might be different in the physician landscape?
A. Again, this is talking about a specific -- this is talking about a reimbursement methodology change.
Q. Right.
A. It's not talking about -- it's not talking about a fee schedule. It's an inpatient reimbursement methodology. And again, when you're looking at inpatient versus outpatient, there are differences. Like outpatient, for example, there are so many different lines of business that you wouldn't necessarily, you know, contract across the board on outpatient. There could be a specific line of business. Lab, for example.
Q. Uh-huh.
A. If you're paying for laboratory services, you wouldn't necessarily guarantee that it was

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going to be budget neutral, because if it was revealed somehow -- and again, this is just speculation -- but if it was revealed that laboratory services were being paid in a nonstandard way --
Q. Uh-huh.
A. -- you wouldn't necessarily guarantee -- you can't say with certainty that that would be the case.
Q. I think I understand your concern. So, let me try and narrow the question.
A. Uh-huh.
Q. Let's include labs and other similar services --
A. Yeah.
Q. -- and let's talk specifically about the drug fee schedule.
A. Yes.
Q. Okay. The drug fee schedule is based on a methodology, right?
A. Right.
Q. And the same way that hospital

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reimbursement is based on a methodology.
A. Uh-huh. Right.
Q. Okay. If Harvard Pilgrim were to change the methodology used to calculate the drug fee schedule, okay --
A. Uh-huh.
Q. -- to implement that change, it would likely have to give a similar assurance to physicians, right, that it would be -- the change would be revenue neutral?
MR. NALVEN: Objection.
Q. Is that a fair statement?
MR. NALVEN: Objection.
A. Again, I can't -- I can't say that with certainty, because, again, the physician contract -- I mean, you've seen -- we don't -- we don't specify, you know, a change to a specific component. We talk about the physician fee schedule.
Q. Uh-huh.
A. So, I can't say with certainty that that's the case.

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Q. Okay. But you can say with certainty that Harvard Pilgrim could change the methodology it uses to calculate the fee schedule if it chose to.
MR. NALVEN: Objection.
Q. Right?
A. Yes.
Q. Could change it from a --
A. Based on the, you know, recontracting.
Q. Right. Right.
A. Yeah.
Q. Subject to contractual obligation.
A. Right. Right. Right.
Q. It could change the methodology from a AWP-based methodology to a WAC-based methodology, an ASP-based methodology?
A. Uh-huh. True.
Q. Anything else if it so choose?
MR. NALVEN: Objection.
A. Yes.
Q. And it could have done so at any point in the past if it so choose.
MR. NALVEN: Objection.

Q. Right?
A. Yes.
Q. Always subject to contractual obligations.
A. Correct.
MR. NALVEN: Objection.
Q. Going to Page 175, which I think you might already be there --
A. Yes --
Q. -- Clause 4.3, can you take a look at that, please. Let me know when you're done.
A. (Witness reviews document.) Okay.
Q. Okay. Now, that provides that Harvard Pilgrim will pay the hospital the lower of the hospital's charges or the amount specified on the fee schedule.
A. Yes.
Q. Is that a fair statement?
A. Yes.
Q. With reference to any particular transaction, okay, if I wanted to go back and figure out whether reimbursement was based on the hospital's actual charge on the fee schedule, how



would I figure that out?
A. I don't know specifically.
Q. Would it be fair to say that I'd have to go and look at claims data pertaining to that particular transaction?
A. Yes.
Q. And, again, turning to Clause 4.8, which is further down that page --
A. Uh-huh.
Q. -- you see the second sentence, "The responsible party will pay the lower of bill charges or the designated fee schedule for all outpatient services where the payment is based on a fee schedule as listed in Exhibit A."
A. Yes.
Q. Here, again, if I wanted to know whether the bill charge or the fee schedule formed the basis for reimbursement in a particular transaction, I'd have to go and look at the claims data, correct?
A. Correct.
Q. I'd like to draw your attention now to



Exhibit A, which starts at HPH 191.
A. Uh-huh.
Q. Now, this exhibit provides the template for the hospital compensation, right?
A. Correct.
Q. It starts off there on 191 with "Inpatient Services," and there are specific amounts listed there. Those are -- although it is 00 in this template, those are per diem rates, right?
A. Correct.
Q. And if you go over to the next page, which is 192, there we have "outpatient rates," which -- underneath "Outpatient Services" it says, "The lower of charges or negotiated rates." And that's the same issue we were just talking about, right?
A. Uh-huh. Correct.
Q. To know which it is, you'd have to look at claims data.
A. Correct.
Q. Do you have a sense as to in what proportion of base cases reimbursement is based on actual charges as opposed to a negotiated rate?



A. I don't.
Q. Okay. And then further along on Page 193, you have a section that refers to "Drugs and Imaging Agents," right?
A. Yes.
Q. Now, that is only in reference to the outpatient services, right?
A. That's correct.
Q. Okay. And this provides for reimbursement based on the HCPC drug fee schedule updated periodically in accordance with Medicare average wholesale price updates, right?
A. Correct.
Q. Now, when you referred earlier to your understanding that average wholesale price is something supplied by Medicare, is this the contracting clause you refer as your basis for that understanding?
A. Yes, it is.
Q. And the HCPC drug fee schedule, that's the same drug fee schedule?
A. Just to correct, that's Harvard Pilgrim

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Health Care not HCPC.
Q. You are quite right. I apologize -- which answers my question, which is to the same fee schedule we've been discussing.
A. Yes.
Q. Turning to Page 195, there is a section providing for price protection terms.
A. Uh-huh.
Q. Are you familiar with this section of the contract?
A. Yes.
Q. What is being discussed here?
A. Okay. What the issue is here is this relates to provider contracts that are percent-of-charge contracts. Because a health plan would have no way of managing the -- the hospital manages its own charge master, its own charge book in setting its own charges. In order to maintain -- if we choose to pay them 80 percent of charges -- and that's an example given here -- if we choose to pay them 80 percent of charges -- we negotiate 80 percent of charges. We don't choose.

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If we negotiate 80 percent of charges, they increase their charges, they would be getting this increase over time. With price protection, we have the right to understand how they're increasing their charges so that we can recalibrate our discount so that we continue to pay them what we originally negotiated and not be subject to fluctuations based on how they're changing their charge book.
Q. Okay. Thank you. Just give me a moment to run through some of these.
A. Sure.
Q. I don't want to repeat questions I've already asked you.
MR. MANGI: Okay. The next document we will turn to is HPH 246 to 282. Mark that, please, as Exhibit 4.
(HPH 246-282 marked Exhibit Farias 004.)
Q. Could you please review that, and let me know when you're done.
A. (Witness reviews document.) I'm fine.
Q. Are you familiar with this document?

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A. Yes.
Q. What is this document?
A. Okay. This document is, again, one of the -- it's a -- again, as I described, a local care unit contract document -- different financial model than what we looked at previously. This is a budget capitation agreement for a limited risk model that Harvard Pilgrim used -- there's a couple of LCs that still have it -- but used it for a couple of years, as its predominant model for a large portion of its LCU network. What this -- the financial terms of this model, the hospitals were "at risk" in a general term -- at risk for Pool 1 or outpatient services -- generally defined as outpatient services. I guess that's the overview.
Q. Okay. When was this -- when you said a couple of years, when was this in use as a predominant model?
A. 2001 and 2002.
Q. And its use was then discontinued, is that correct?
A. It -- many of the LCUs were migrated, if

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you will, to the document that we looked at previous -- under the terms of the document that we looked at previously, a fee-for-service arrangement with the quality advance program.
Q. What was the basis for the decision to move from budgeted capitation agreements to the alternative arrangement?
A. Generally, just, again, it was really a marketplace thing. The old -- the risk-sharing arrangements that physicians were under -- and again, this is really global, it's not really specific to Harvard Pilgrim -- general trend away from the budgeted capitation or risk-sharing agreements for a large percentage of the network that generally smaller type practice -- practices that don't have sophisticated infrastructure so they can manage under the terms of a risk arrangement.
Q. Uh-huh.
A. And again, the general trend in the marketplace to pay for performance programs, such as quality advance. Again, physician

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representations that they want to get, you know, incentive -- they will incentivize more in a focused way for things that they had direct control over.

Q. Uh-huh. Describe for me, if you would, how the arrangement contemplated by this agreement would work.

A. Okay. The financial arrangement would be -- well, any -- a budget capitation arrangement -- a budgeted cap amount would be set. That would be described in the terms of the profit and loss statement as the revenue to the LCU, local care unit. Budget capitation amount would be set. Their performance would be measured against expenses. And the expenses were a representation of the aggregate medical costs of providing services. Again, looking at Pool 1 only, which are outpatient services.

Q. Uh-huh.

A. So, we would measure the budgeted capitation revenue against the medical cost expense at the end of the year and understand if there was

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a, you know, not for-profit, but profit or loss in terms of a P&L, a profit or loss. If there was a profit, the LCUs would share in that profit. If there was a loss, subject to a withhold -- like the claims that are paid for the physicians would be subject to a withhold -- that withhold would be held back to cover any losses. If there was a partial, you know, loss, they would use the withhold and then return the withhold back. Just a standard risk arrangement within the market.

Q. Okay. So, pursuant to the terms of these agreements, the amount that was paid in the first instance was a capitated amount. And there was no separate --

A. No.

Q. I'm sorry. Go ahead.

A. The distinction is budgeted capitation.

Q. Okay.

A. This is a paper -- really a paper accounting. A memorandum account, if you will.

Q. Okay.

A. Direct capitation, which you're referring

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to, direct capitation is you pay amount, irrespective of the services, and the group has full risk. Okay. So, this is budgeted capitation. They are paid for the services that they provide on an ongoing basis, according to fee schedules, standard fee schedules, and so forth. And that's what represents the expenses in the memorandum account, and then there's a settlement process at the end of the year.

Q. I see. I see. So, the amounts that are actually paid throughout the year prior to the settlement would be similar to the amounts that are being paid currently under the different type of arrangement?

A. That's correct, yes.

Q. And would the amounts that were paid pursuant to these agreements prior to the settlement include a drug component based on a fee schedule?

A. They could, although at this moment, and I know there's an exhibit in here that will tell us what was included -- right. They would have been

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paid that way, right.

Q. Okay.

A. Right.

Q. Why don't we take a look at the exhibit you were talking about.

A. Uh-huh. Sure.

Q. Are you referring to Page 276?

A. Yes, I am.

Q. Okay. So, this is Appendix E. See where it says, "included in and excluded from capitation revenue"?

A. Uh-huh.

Q. It starts off with, "The services included in the budgeted capitation revenue --"

A. Uh-huh.

Q. Part B of that is, "Physicians Administered --" I'm sorry. "Pharmaceuticals administered --"

A. (Witness reviews document.) I'm reading from Appendix E, 1-B, "Pharmaceuticals administered in a physician's office or on an outpatient basis in a hospital facility, these services are included

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in the budgeted capitation revenue delineated in Appendix C."
Q. Right. So, during the -- since this was in the 2001/2002 time period, payments then would have been based on the 95 percent of AWP methodology in the first instance, right?
A. Yes.
Q. Then at the end of the year, those total amounts would be compared to the budgeted capitated amount, which would then form the basis for a distribution of either the profit or the deficit. Is that a fair statement?
A. Yes, but understanding that the budgeted capitation amount is an aggregate number. It's not identified separately by different components. It's a single number.
Q. Right. Okay. If I could draw your attention to 271, HPH 271, you will see, sir, towards the top of the page they are called D-1 and D-2. These provide the terms of surplus distribution or deficit sharing, right?
A. Yes.

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Q. And since this is a template, the percentages in which the surplus or the deficit will be distributed or shared are blank. Did those percentages vary from contract to contract?
A. They could vary.
Q. Okay. Do you know of instances where they did vary?
A. Not specific instances that I could cite, no.
Q. Okay. So, you don't know whether they did vary or they didn't? Well, let me withdraw that question. Do you have any basis for knowing whether or not this did, in fact, vary from contract to contract?
A. Based on the contract form, I would.
Q. Based on the fact that it's a blank.
A. Yes.
Q. Okay. So, your assumption would be that that was a -- those percentages were negotiated from contract to contract?
MR. NALVEN: Objection.
A. Again, our approach would be that there would be a standard distribution, but I don't know.

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Q. Okay. Well, your assumption, based on the fact that they are blank, is that there was variation?
A. Right.
MR. NALVEN: Objection.
Q. Okay. And if there was variation, the basis for that variation would have been negotiation between the contracting parties, right?
A. Correct. Correct.
MR. NALVEN: Objection.
Q. Okay. If I wanted to know in any particular case what the distribution was, I'd have to go and look at the particular contract, right?
A. That's correct.
MR. MANGI: Off the record.
(Recess was taken.)
Q. Now, we've spoken about average wholesale price today, and we've also spoken about wholesale acquisition cost or WAC, right?
A. Yes.
Q. Do you have any understanding of what the relationship is between those two benchmarks?
A. I don't.
Q. Okay. Do you have an understanding as to whether one is generally higher or lower than the other?
A. I don't.
Q. Okay. Now, we've also spoken about a number of instances where fee schedules are negotiated, right?
A. Correct.
Q. Now, in those instances -- or indeed in any case where Harvard Pilgrim is making payments to a provider -- Harvard Pilgrim is looking to get the best deal that it can, right?
MR. NALVEN: Objection.
A. I don't know that I would represent it that way.
Q. Okay. How would you represent it?
A. There are lots of contracting motivations. I mean -- and, as we talked about earlier, you know, predominant is maintaining a comprehensive and stable network.

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Q. Okay. Let's take that as a consummate. Let's assume that there is a network sufficient to ensure coverage for Harvard Pilgrim's members.
A. Uh-huh.
Q. In that case, when choosing between alternatives, Harvard Pilgrim will choose the most cost effective option, right -- assuming all else is equal?
A. Uh-huh. Yes.
Q. Okay. 'Cause Harvard Pilgrim is a for-profit entity, right?
A. No.
Q. No. It's not a for-profit entity? Really? It's a not-for-profit entity?
A. That's correct.
Q. Okay. But Harvard Pilgrim is still looking to operate on the most effective business model possible, right?
A. Yes. Yes.
Q. Okay. Harvard Pilgrim's efforts to ensure that it gets the best deal that it can would --
MR. NALVEN: Object -- sorry.

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MR. MANGI: I'll withdraw that, and I'll start again.
Q. So, we can agree, right, that, subject to an adequate coverage network and all those other factors being in place, Harvard Pilgrim is looking to get the best deal that it can, right?
A. That's your terminology.
Q. Sure.
A. My -- I would represent it as fair reimbursement, and I wouldn't -- I wouldn't characterize it that way.
Q. Okay. So, it's looking to get fair reimbursement on the terms that are most cost effective to Harvard Pilgrim, right?
A. Yes.
Q. Okay. And that remains the case in the hospital sector, even though it's changed -- Harvard Pilgrim is changing the methodologies from a per diem rate to a DRG-based rate, correct?
A. Could you help me with the question, please.
Q. Sure.

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A. I'm --
Q. Even in the hospital sector Harvard Pilgrim is changing its reimbursement methodology from per diem to a DRG-based reimbursement for inpatient, right?
A. Correct.
Q. And while that change is taking place, it doesn't affect the fact that Harvard Pilgrim is seeking to ensure it makes reimbursement at the most cost effective basis possible, right?
A. Cost -- right, yes.
Q. That fact is a constant that's not altered by a change in the reimbursement methodology, right?
A. Correct.
Q. Okay. And the same would be true if changes were made in the physician reimbursement methodology. Harvard Pilgrim would still be looking to make reimbursement on the most cost effective basis possible, right?
A. Yes.
Q. Okay. Okay. So, that could be true,

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regardless of whether reimbursements currently tied to AWP were tied to another benchmark -- say WAC or ASP, right?
MR. NALVEN: Objection.
A. Yes.
Q. In other words, that remains -- that motivation remains a constant, regardless of the methodology that's in use.
MR. NALVEN: Objection.
A. Yes.
MR. MANGI: That is all the questions I have for now.
CROSS-EXAMINATION
BY MR. NALVEN:
Q. Mr. Farias, I'm David Nalven. I represent the Plaintiffs in this case. I have just a few questions.
A. Sure.
Q. In connection with establishing a fee schedule for prescription drugs that are administered by doctors, what is Harvard Pilgrim seeking to cover in reimbursing doctors for the

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prescription drugs they administer?
A. The drugs.
Q. And the drugs alone, right?
MR. MANGI: Object to the form.
A. Yes.
Q. Does Harvard Pilgrim view its reimbursement of physicians for prescription drugs as an opportunity for the physicians to mark up the physician's drug costs?
MR. MANGI: Object to the form.
A. Could you repeat the question, please.
Q. Does Harvard Pilgrim view its reimbursement of physicians for prescription drugs as an opportunity for the physicians to mark up the cost of the physician's drugs?
MR. MANGI: Object to the form.
A. No.
Q. Do you know the prices that doctors pay for prescription drugs that they administer?
A. No.
Q. Are you aware of rebates that are paid by manufacturers to physicians in connection with

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drugs purchased by physicians?
A. I have heard in general terms about rebate, but I don't know what they are or how they work.
Q. What do you know about rebates paid by --
A. I've heard the term in or seen the term in literature about pharmacy rebates. That's really it.
Q. Have you ever seen any information concerning the magnitude of rebates paid by pharmaceutical manufacturers to doctors for the drugs --
A. No.
Q. -- that doctors purchase?
A. No.
MR. MANGI: Object to the form.
Q. Is it important to Harvard Pilgrim that its prices -- that the rates at which it reimburses doctors in connection with prescription drugs be as accurate as possible?
MR. MANGI: Object to the form.
A. It's difficult -- I don't really

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understand what you're saying as far as "accurate as possible."
Q. Well, is it important that you fairly reimburse physicians for the drugs that they purchase and then administer?
A. As a general concept, it's important that we fairly reimburse.
Q. Okay. Does Harvard Pilgrim have an interest in controlling its expenditures in connection with the administration of prescription drugs by physicians?
A. Again, I can talk about that as a general concept that it is important for a responsible health plan to manage medical cost trends.
Q. When you say, "medical cost trends," what do you mean?
A. I mean that, again, this is my representation that I think it's a given that medical costs will -- you know, are projected to increase by a certain percentage over time. And as a responsible health plan or health administrator, that you would want to manage the projection of

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those trends. I mean, you can't assume that it's going to be flat. Again, this is a marketplace discussion. But you can't assume that, you know, that you have any ability to maintain level funding; that there is going to be an incremental increase over time and that -- we would manage the medical cost trend.
Q. But within those trends, Harvard Pilgrim's goal is to control its drug spending, isn't it?
A. That could be a component, yes.
Q. Now, you were asked earlier about whether Harvard Pilgrim had ever proposed to its providers that it use a different basis other than AWP for setting reimbursement. Do you recall that?
A. I -- I didn't take the question as did we propose it to our providers, as had we had discussions about it.
Q. And you said that you had not.
MR. MANGI: Object.
A. We've had internal discussion about it, but we hadn't proposed anything to our providers.
Q. Correct. And I guess the question I have

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is why not?
A. As I describe, because we were looking at the Medicare state and because of it being in fluctuation, we didn't have a landing spot yet.
Q. But even before the notion of ASP was introduced through the recent Medicare reform legislation --
A. Uh-huh.
Q. -- there may still have been opportunities to propose to providers a different way of determining reimbursement rates, wouldn't there have been?
MR. MANGI: Objection. Form. Foundation.
A. There could have been.
Q. But as far as you know, Harvard Pilgrim has used AWP as the basis for reimbursement.
A. Correct.
Q. Now, why is that?
A. I don't know.
Q. Well, is it because it's a term that everybody who's involved in the health care industry and profession has heard of?

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MR. MANGI: Object to the form.
A. I can't say that's the reason.
Q. Is it because everybody uses it?
MR. MANGI: Object to the form.
A. I can't say.
Q. Do you understand AWP to be an industry standard?
A. That's my understanding, yes.
Q. And it's also a standard and a price list that's reflected in what Harvard Pilgrim receives from Medicare, right?
MR. MANGI: Object to the form.
A. I'm not sure I understand.
Q. Harvard Pilgrim receives AWP pricing from Medicare.
A. Oh, the pricing. Right, yes.
Q. And so, as a result of its coming from Medicare, does that provide Harvard Pilgrim with a degree of confidence in its accuracy?
MR. MANGI: Objection. Form. Foundation.
A. I mean, explicitly, do we think in those terms, no. But generally, a larger data set -- and

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I can talk about, again, our general -- our RBRVS-based physician fee schedule where we rely on the RBUs that are provided through Medicare because of the size of the data set. Again, this isn't related directly to drugs, but it is a larger data set. So, you can make that call.
Q. Well, I'm really trying to understand --
A. Yeah.
Q. -- why it is that Harvard Pilgrim has and continues to use and rely on AWP.
A. Right. Right.
Q. And so, that's why I turned to Medicare.
A. Sure.
Q. And I'll ask whether the fact that Medicare is large --
A. Right. Right.
Q. -- Medicare is run by the United States government --
A. Uh-huh.
Q. -- does that influence Harvard Pilgrim's judgment --
MR. MANGI: Object.

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Q. -- to the accuracy of AWP?
MR. MANGI: Object to the form.
A. Again, I don't think it explicitly affects our judgment. Again, as I said, AWP is, from my perspective an industry standard, and that's why we would use that.
Q. And are you aware of the office of the inspector general in the health and human services administration?
A. Yes.
Q. What do you understand the office of the inspector general to be?
A. Well, today, I don't know. My previous hospital experience as being in the reimbursement area, I was aware of the office of inspector general looking at one thing that we would have to do is research the federal register and review, you know, publications from the office of inspector general, Medicare sanctioned providers, that type of thing in a general way.
Q. So, it's an investigatory agency.
A. Yeah. Uh-huh.

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Q. And it's a watchdog.
A. Uh-huh.
Q. And it's there to protect Medicare.
MR. MANGI: Object to the form.
Q. Is that your understanding?
A. If that's what -- I don't know.
Q. Well --
A. I would assume that's what it is, based on my knowledge.
Q. And so, Medicare is not only large, but it also has this investigatory agency that is a watchdog for it.
MR. MANGI: Object to the form.
Q. Is that your understanding?
A. Yes.
Q. And Medicare has a pretty large budget, doesn't it?
A. Yes.
Q. Medicare -- do you know what Medicare spends a year on prescription drugs?
A. I don't know.
Q. Do you know what portion of all

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prescription drugs purchased in the United States are reimbursed by Medicare?
A. No.
Q. Is it 10 percent, 20 percent, do you know?
MR. MANGI: Object to the form.
A. I don't know.
Q. But it's a large amount.
MR. MANGI: Object to the form.
A. I don't know.
Q. The reason I ask is I'm just wondering whether the fact that Medicare is large reimburser --
A. Uh-huh.
Q. -- of prescription drugs, explicitly or implicitly, does that influence your thinking as it relates to the confidence that you have in information concerning AWP received from Medicare?
MR. MANGI: Object to the form.
A. See, it's not so much the size, but it's really the -- I think more of a standardization. If this is, you know, an industry standard approach, as with hospital DRG methodology -- DRG

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is a well-known standard methodology of reimbursing inpatient services, and that's the methodology that Medicare employs. So, in that way you could say based on size that it would have some merit.
Q. What is your understanding of the role the pharmaceutical manufacturers have in setting AWP?
A. I don't know what that is.
Q. You're not aware of any role that manufacturers play in setting AWP, is that correct?
A. Well, as in any industry, you know, people set their prices. I don't know the methodology.
Q. Now, you were asked earlier whether the physicians' acquisition cost for drugs would affect the amount that Harvard Pilgrim reimbursed them.
A. Right.
Q. And I thought that you had answered that it wasn't one of the factors that went into your determining what you reimbursed physicians.
A. Right. I was asked if I knew what physicians paid for the drugs. My answer was no. And if my answer is no, I don't -- we wouldn't -- we couldn't use that to determine.

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Q. So, when you said that it wasn't relevant in your determination --
A. Uh-huh.
Q. -- as to what to reimburse physicians, the reason that it's not relevant is because -- the reason that you said it was not relevant -- just to clarify your answer -- is because --
A. Uh-huh.
Q. -- you didn't have that information. Is that what you were saying?
A. Well, I'm just saying that I couldn't use the information to do it. I mean, it just wouldn't -- it wouldn't be -- it wouldn't come into play.
Q. It wouldn't come into play because you don't have it. Is that what you mean?
MR. MANGI: Object to the form. Mischaracterizes his testimony.
Q. Let me ask it a different way.
A. Yeah.
Q. Just to make sure.
A. Uh-huh.
Q. This is really to understand --

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A. Sure.
Q. -- your testimony. Let's suppose that you did the have the physician's actual acquisition cost --
A. Uh-huh.
Q. -- would that information be used in Harvard Pilgrim's determining what it would reimburse physicians for prescription drugs that the physicians administered?
MR. MANGI: Objection. Asked and answered.
A. I don't know if it would be.
Q. Well, let me ask you this: You testified earlier that you're generally aware from your life experience --
A. Uh-huh.
Q. -- that physicians receive free samples.
A. Yes.
Q. Are you aware whether physicians receive free samples of drugs that they administer?
A. I don't know what the nature of the samples are that they receive.

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Q. Let's suppose that a physician receives a free sample, administers it to a patient who's a Harvard Pilgrim member -- are you with me --
A. Uh-huh.
Q. -- and then charges Harvard Pilgrim for that drug that the doctor received for free and administered to the patient --
A. Uh-huh.
Q. -- would Harvard Pilgrim think it relevant in determining whether to reimburse the doctor for that drug that the doctor got it for free?
MR. MANGI: Object to the form, and also you're asking him to assume that the physician commits a crime.
Q. You can answer the question.
A. I -- I don't know that we -- I don't know. I don't know that we would go into that -- I don't know that we would make any assumptions about that.
Q. No, I understand that. But I'm asking you to make an assumption. I'm asking you to assume that the doctor receives the drug for free.
A. Uh-huh.

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Q. Would Harvard Pilgrim consider that relevant in determining whether to pay the doctor for the drug cost or not?
MR. MANGI: Again, objection to the form and improper hypothetical to the extent you're asking him to assume the physician commits a crime.
A. No, we wouldn't -- we wouldn't factor that in. We wouldn't do that level of exploration.
Q. Again, though, Mr. Farias, I understand that you wouldn't do that level of exploration, but I'm asking you to assume that the doctor got the drug for free. Would you reimburse the doctor, based on AWP minus 5 percent, even though the doctor got it for free? Would that be relevant to you that the doctor got it for free?
MR. MANGI: Same objections.
A. If the provider submitted a claim in conformance with his contract, provider submitted a claim for a covered service, Harvard Pilgrim would reimburse for that service under the terms of the contract.
Q. For the service. And when you say, "the

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service," you mean, as well, the drug?
A. Right.
Q. And is that because you assume that the doctor, in submitting that bill, paid for the drug?
MR. MANGI: Object to the form.
A. Not -- again, not at that level of detail. We would be assuming that the provider is performing under the terms of his contract or her contract with Harvard Pilgrim.
Q. Okay. So, when you give me that answer, you really think about it in terms of at the level of the claims submission?
A. That's correct.
Q. Okay. What about at the larger level, just in general if the doctors -- if the doctor is generally administering drugs that it receives for free and you know that?
A. I don't know that.
MR. MANGI: I'm sorry. Just to avoid me interrupting --
MR. NALVEN: I'm sorry.
MR. MANGI: -- can I have a standing

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objection to this line of questioning so I don't interrupt you again?
MR. NALVEN: Of course you may. Of course you may.
Q. If you would assume as a hypothetical question that the doctor has no costs -- no drug costs in connection with its administration of drugs, would that influence Harvard Pilgrim in its determination of how much to reimburse doctors in connection with their administration of drugs?
MR. MANGI: It's a different question, so I'll object to the form.
A. I'm having a really tough time making an assumption that I can't see as a valid assumption. I'm sorry.
Q. And what's the assumption that you don't understand to be a valid assumption?
A. That physicians aren't paying for drugs.
Q. Okay. Well, may I ask you to assume that fact, even though you don't believe that it's a valid assumption.
MR. MANGI: Are you asking him to assume

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that all physicians are getting drugs for free?
Q. You can answer the question.
MR. MANGI: Object to the form then.
A. Okay. You can ask me to make that assumption.
Q. Okay. Now, if you assume that the doctor receives the drug for free, would that influence Harvard Pilgrim's decision as to whether to pay the doctor -- reimburse the doctor for providing the drugs to one of Harvard Pilgrim's members?
MR. MANGI: Object to the form.
A. It could.
Q. Under what circumstances?
A. But I have to say, under the terms of our provider contracts, we agree to reimburse for covered services, as defined in member contracts. So, if these are covered services, we have agreed to pay for those services. And where they're coming from or what they're paying -- that is not a consideration.
Q. Okay. So, you would reimburse because you feel like that's your legal obligation under the

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contract.
MR. MANGI: Object to the form.
A. Because it is our legal obligation under the contract.
Q. If you had information that physicians were getting discounts and rebates that allowed them to purchase the drugs that they administer at 10 percent of the cost that Harvard Pilgrim reimburses them, when you negotiate your next contract with the physicians, would the fact that they pay only 10 percent of what you had previously reimbursed them under the old contract influence your judgment as to whether to change the reimbursement rate?
MR. MANGI: Object to the form and also foundation in that the witness is not involved in negotiations.
A. Could you restate that, please.
Q. You're coming to the end of a contract period --
A. Yes.
Q. -- you learn that the physician pays only

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10 percent of the cost that you, Harvard Pilgrim, have been reimbursing them all along for a drug --
A. Uh-huh, right.
Q. -- and that they're getting a 90 percent profit on the drug --
A. Uh-huh.
Q. -- when you turn to renegotiate that contract, would the fact that the doctor pays only 10 percent of what you are reimbursing --
A. We don't but --
Q. -- influence your judgment?
A. We talked about before, we don't negotiate our physician -- our drug fee schedule.
Q. And that's because you rely on the Medicare AWP.
MR. MANGI: Object to the form.
A. Well, no, that's not because. We do use AWP as a basis, yes. But that's not the reason why we don't negotiate it. We, as I said before, we don't negotiate it because we want standardization across the network.
Q. Okay. Well, what if you came to

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understand that every physician was obtaining the drugs that it administered to Harvard Pilgrim patients at 10 percent of the amount that Harvard Pilgrim --

A. Uh-huh.

Q. -- was reimbursing them --

MR. MANGI: Object to the form. And are you asking about all drugs?

Q. -- would that influence Harvard Pilgrim's judgment in setting its reimbursement rates?

MR. MANGI: Same objection.

A. Under -- and I can only speak in general terms. Understanding generally what the marketplace is and what the benchmarks are in the marketplace, it could.

Q. Including the physicians' costs.

MR. MANGI: Object to the form.

A. Again, I don't know. I don't know how we're defining physician costs. I can't answer that.

Q. Okay. You don't have any information concerning what physicians pay for the drugs, do

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you?

A. No.

Q. And so, as a result of not having that information, you're not able to make judgments concerning Harvard Pilgrim's reimbursement rates based on the actual acquisition costs, are you?

MR. MANGI: Objection. Form. Foundation.

A. No.

MR. NALVEN: Okay. Thank you. I have nothing further.

REDIRECT EXAMINATION

BY MR. MANGI:

Q. I have a few more questions, I'm afraid.

A. Sure.

Q. In response to one of Mr. Nalven's questions earlier, you said it's important for Harvard Pilgrim to fairly reimburse for drugs. What did you mean by that?

A. Again, I didn't mean it to be specific to drugs. I just mean in general terms.

Q. Okay.

A. Fairly reimburse is to reimburse

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appropriate to the marketplace some reasonable representation of cost. And again, I'm talking in general terms, not specific to reimbursement, but just the general reimbursement, you know, strategy and approach and thinking that we would fairly compensate for services rendered.

Q. Well, fair reimbursement would include an element of profit to a pharmacy or a physician, correct?

A. It could, yes.

Q. Because Harvard Pilgrim certainly would not consider a fair reimbursement to be reimbursement that was exactly equal to acquisition costs, right, because then a pharmacy or provider would be making no money?

A. That would be true -- I mean, again, I can talk in general terms.

Q. Sure.

A. It's very hard from my position to talk about specific lines of business as it relates to reimbursement.

Q. So, general terms.

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A. In general terms -- in general terms a health plan would recognize that there are overhead costs that need to be covered as part of the reimbursement equation.

Q. Right. And in addition to covering overhead costs, businesses need to make money, right? Pharmacies and providers need to make money, and Harvard Pilgrim recognizes that fact in the marketplace, right?

MR. NALVEN: Note my objection.

A. Again, I mean, I can talk about the -- you know, the cost-plus margin, again, general approach --

Q. Uh-huh.

A. -- making money is a difficult concept for me, being in a nonprofit.

Q. Okay. Let me rephrase the question then --

A. Okay.

Q. -- then in a way that makes more sense. The cost element includes acquisition costs and overhead costs and other costs?

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A. Correct.
Q. Right?
A. Uh-huh.
Q. Now, Harvard Pilgrim recognizes that when reimbursing providers and pharmacies, a fair reimbursement would be an amount of reimbursement that covers all of those costs and includes an element of margin, right?
A. Yes.
Q. Now, you understand that -- withdraw that. We discussed earlier the reimbursement for drugs and the reimbursement that goes as an administration fee.
A. Right.
Q. Right? Do you have an understanding as to whether or not the administration fees that Harvard Pilgrim pays to providers are sufficient to cover their overhead costs?
MR. NALVEN: Objection.
A. I don't know specifically, no.
Q. Okay. If it transpired that the administration fees paid were inadequate --

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A. Uh-huh.
Q. -- to cover overhead costs --
A. Right.
Q. -- then for the reimbursement that Harvard Pilgrim pays overall to be fair --
A. Uh-huh.
Q. -- the amount paid in reimbursement for drugs would have to subsidize an inadequate administration fee, right?
MR. NALVEN: Objection.
A. Yeah.
Q. I'm sorry. Your answer was yes?
A. Yes. And, again, I'm --
Q. General terms.
A. Harvey's going to tell me I'm saying too much.
THE WITNESS: I'm sorry.
MR. COTTON: Explain your answer. That's fine.
A. Again, in general reimbursement terms, that's why I keep saying it's difficult for me to say in specific lines of business, again, just

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because of the nature, and it's not because of what Harvard Pilgrim does. It's not because of what specific providers do. But the nature of what reimbursement is and how it's evolved over time, that it's very difficult, within lines of business, to say -- and again, I'm going to keep using hospitals to make this generic -- but for laboratory services, that what we pay for laboratory is an appropriate charge -- you know, cost plus margin for laboratory, for radiology, it's -- it is, you know, a mix of services across the board. So --
Q. I hear you.
A. Okay.
Q. But as a general proposition, it's fair to say that in every case for -- to fairly reimburse you are looking to cover cost, plus margin.
A. An appropriate margin, yeah.
Q. Okay. Now, in response to other questions from Mr. Nalven, you said that you have heard about manufacturer rebates, is that correct?
A. Yes.

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Q. You heard about manufacturer rebates and discounts to providers.
A. Again, I'm really sketchy. I mean, I know I've heard about it, but I don't know who and how it works.
Q. Okay. It's fair to say that you know that manufacturers do contract with providers to give them rebates and discounts, but you don't know anything more about that phenomenon.
A. I've heard, you know, "drug rebates" as a phrase, but I don't know.
Q. Do you know whether those contracts exist in the marketplace?
A. I -- I don't know that it's a contract. I don't know what the --
Q. Okay. Let me put it another way.
A. -- vehicle is.
Q. You understand that manufacturers do provide discounts and rebates to providers.
A. Uh-huh. Yes.
Q. Now, Mr. Nalven asked you some questions about whether manufacturers set AWP. Do you know

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who sets AWP?
A. I -- again, I didn't know that it was set. I don't know.
Q. Okay. So you have no idea who sets AWP.
A. Right.
Q. You referred to AWP as being an industry standard.
A. Yes.
Q. When you say that, do you understand that it's standard of the industry to use AWP as a reimbursement benchmark, correct?
A. Yes.
MR. NALVEN: Objection.
Q. And you understand that it's standard in the industry to reimburse at a discount off AWP, correct?
A. Yes.
Q. Mr. Nalven asked you a bunch of questions about OIG and Medicare.
A. Uh-huh.
Q. You're not an expert in OIG or Medicare, are you?

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A. No.
Q. So, you were just testifying about your general impressions, is that right?
A. Based on previous experiences, yes.
Q. Okay. But you have no precise knowledge about what the role of OIG is in relation to Medicare.
A. No.
MR. NALVEN: Objection.
Q. Now, then there were a whole bunch of questions about whether or not -- well, your knowledge of physicians' acquisition costs and so on.
A. Yes.
Q. Let's see if we can get that straight in my mind, based on your earlier testimony when we were speaking.
A. Uh-huh.
Q. Physicians' acquisition costs form no part of Harvard Pilgrim's reimbursement methodology, right?
A. Correct.

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Q. So, if a physician were committing a crime and billing for a drug that he had got as a free sample, Harvard Pilgrim would still reimburse him, but would hope that the authorities would catch up with him, right?
A. I think that's safe to say.
Q. And Harvard Pilgrim doesn't have any knowledge about what providers' acquisition costs are, right?
A. No.
Q. Doesn't require them to disclose those.
A. No.
Q. And if it learned that those were higher or lower than it currently thinks they are, that wouldn't change the fact that it reimburses that methodology, which is 95 percent of AWP?
A. Correct.
Q. Indeed, if it learned that in a particular instance physicians were getting a particular drug at a -- were getting a rebate or a discount from a manufacturer on a particular drug, that wouldn't change the fact that Harvard Pilgrim's standard

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across the board methodology is 95 percent of AWP?
A. Correct.
MR. NALVEN: Objection.
MR. MANGI: That's it.
MR. NALVEN: I have nothing further.
THE WITNESS: Okay. Great.
(Whereupon the deposition ended at 12:52 p.m.)

Commonwealth of Massachusetts
Middlesex, ss.

I, P. Jodi Ohnemus, Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that there came before me on the 20th day of October, 2004, the deponent herein, who was duly sworn by me; that the ensuing examination upon oath of the said deponent was reported stenographically by me and transcribed into typewriting under my direction and control; and that the within transcript is a true record of the questions asked and answers given at said deposition.

I FURTHER CERTIFY that I am neither attorney nor counsel for, nor related to or employed by any of the parties to the action in which this deposition is taken; and, further, that I am not a relative or employee of any attorney or financially interested in the outcome of the action.



IN WITNESS WHEREOF I have hereunto set my hand and affixed my seal of office this 20th day of October, 2004, at Waltham.

_____

_____

P. Jodi Ohnemus, RPR, RMR, CRR
Notary Public,
Commonwealth
of Massachusetts
My Commission Expires:
4/21/2007